California Medi-Cal Dental Program

Denti-Cal Bulletin

VOLUME 19, NUMBER 1 P.O. BOX 15609 SACRAMENTO, CALIFORNIA 95852-0609 JANUARY 2003

CHANGES IN PROCEDURES AND CRITERIA FOR COUNTY MEDICAL SERVICES PROGRAM (CMSP)

The CMSP has changed the following procedure and adjudication reason codes, as noted below, for dates of service beginning January 1, 2003.

Procedure 015 Examination Periodic

Procedure 015 is a benefit available only **once** in a twelve-month period for CMSP beneficiaries (Aid Codes 8F, 50, 84, 85, 88, and 89). A new adjudication reason code has been created to assist with the processing of Procedure 015. Adjudication Reason Code 002B will read as follows:

> **002B: Procedure 015 is a benefit once in a twelve-month period for CMSP beneficiaries.**

Adjudication Reason Code 002A has been modified to explain the change in benefits for CMSP beneficiaries, when Procedure 015 is billed within six months of Procedure 010. Adjudication Reason Code 002A now reads as follows:

> **002A: An examination is not a benefit within six months of a previous examination, to the same provider, for patients under age 21 or CMSP beneficiaries.**

Procedure 050 Prophylaxis, Beneficiaries Age 13 and Over

CMSP beneficiaries will be allowed one Procedure 050 per twelve-month period.

For additional information please telephone Denti-Cal toll-free at (800) 423-0507.

California Medi-Cal Dental Program

Denti-Cal Bulletin

VOLUME 19, NUMBER 2 P.O. BOX 15609 SACRAMENTO, CALIFORNIA 95852-0609 JANUARY 2003

Each of these previously released articles are being presented to address the many questions received regarding treatment of crowns as specified by the Denti-Cal program.

ADJUDICATION REASON CODES FOR CROWNS REQUESTED ON CHILDREN

Developmentally immature teeth are defined as follows: teeth that have not fully erupted into the arch; teeth that have adjacent or opposing teeth that have not fully erupted into the arch, or teeth with large pulpal chambers that are subject to irreversible pulpal damage if prepped.

Adjudication Reason Code 113B indicates that authorization for laboratory-processed crown requests have been disallowed for beneficiaries under the age of 16 years, when the tooth is developmentally immature or the arch demonstrates an incomplete eruption pattern. Adjudication Reason Code 113B reads:

> **113B** Per x-rays, documentation, or clinical evaluation, tooth is developmentally immature. Please reevaluate for a more conservative restoration, i.e., SSC, amalgam, or composite.

Adjudication Reason Code 613B corresponds with laboratory-processed crown requests for beneficiaries under the age of 16 years, when the tooth is developmentally immature and the patient has been screened. New Adjudication Reason Code 613B reads:

> **613B** Per clinical evaluation, tooth is developmentally immature. Please reevaluate for a more conservative restoration, i.e., SSC, amalgam, or composite.

CLARIFICATION OF CRITERIA FOR LABORATORY-PROCESSED CROWNS ON ANTERIOR TEETH

Denti-Cal offers the following clarification regarding the authorization of laboratory-processed crowns on anterior teeth (procedures 650-653).

To allow a Treatment Authorization Request (TAR) for a laboratory-processed crown on an anterior tooth, radiographs submitted with the TAR must show evidence of *any* of the following criteria:

1. The involvement of four (4) or more surfaces, including at least one incisal angle. The facial or lingual surface shall not be considered as involved for a mesial or distal proximal restoration unless the proximal restoration wraps around the tooth to at least the midline.
2. The loss of an incisal angle involving a minimum area of both one-half the incisal width and one-half the height of the anatomical crown.
3. An incisal angle that is not involved, but more than 50 percent of the clinical crown appears to be involved.

Narrative documentation included with the TAR and radiographs must substantiate the radiographic evidence.

ENDODONTIC TREATMENT WILL NOT BE ALLOWED WHEN PERFORMED ON IMMATURE PERMANENT TEETH

Denti-Cal will not allow Treatment Authorization Requests (TARs) for root canal therapy for children under the age of 18 when the treatment is performed on a tooth with incomplete apical development. In these cases, the treatment will be denied with the following Adjudication Reason Code:

293 Per x-rays or clinical evaluation, procedure requested is inadequate to correct problem. Please submit alternative treatment plan.

a. X-rays reveal opened, underformed apices. Authorization for root canal therapy will be considered after radiographic evidence of apex closure following apexification.

If a TAR is denied for this reason, the provider can submit a new claim for procedure 534 (apexification/apexogenesis). Upon completion of procedure 534, a new TAR for the endodontic procedure may be submitted, along with x-rays demonstrating sufficient apical formation.

In some instances, root canal therapy has been attempted on immature permanent teeth, causing Denti-Cal to deny subsequent requests for laboratory-processed crowns using the following Adjudication Reason Code:

284C Radiographs reveal that additional procedures are necessary before authorization of the requested service(s) may be made; endodontic treatment incomplete.

The provider may wish to re-evaluate the case when the laboratory-processed crown has been disallowed and submit a new TAR for procedure 531 if an apicoectomy is required. (Be sure to include x-rays depicting the completion of procedure 531 when submitting a new TAR for consideration of the laboratory-processed crown.)

Please refer to the Manual of Criteria in section 4 of the *Denti-Cal Provider Manual* for the specific requirements for these procedures.

STUDY MODELS NOT ACCEPTED UNLESS REQUIRED OR REQUESTED

Denti-Cal will accept study models for cases involving orthodontia, oral surgery and maxillofacial procedures only. Study models submitted for all other procedures (crowns, prosthetics, etc.) will be discarded unless Denti-Cal specifically requested the models to evaluate the claim or authorization request.

Narrative documentation, radiographs and/or photographs are sufficient documentation for other procedures. To be considered adequate, narrative documentation should be as specific as possible and radiographs must be of diagnostic quality.

FIXED BRIDGE PONTICS (PROCEDURES 680-682, 692, 693)

Fixed artificial prostheses (crowns with attached pontics) are benefits with prior authorization when necessary in order to obtain employment or where medical conditions preclude the use of removable dental prostheses.

Who qualifies for fixed bridge pontics? A beneficiary with missing natural teeth may qualify for a fixed artificial prosthesis if it is determined that lack of such prosthesis would interfere with the beneficiary's suitability for employment. A statement from the beneficiary's case manager or eligibility worker, written on official letterhead of the case manager's or eligibility worker's government agency, shall be included with the Treatment Authorization Request (TAR). This statement must certify the need for fixed replacement of missing teeth in order for the beneficiary to gain employment.

Authorization requests for fixed artificial prostheses will not be approved if the proposed treatment is not medically necessary or when a removable prosthesis meets the patient's needs.

Conditions precluding the use of removable prosthesis: The following medical conditions preclude the use of removable dental prostheses. Such conditions include, but are not limited to:

1) The epileptic patient where a removable prosthesis could be injurious to his/her health during an uncontrolled seizure.
2) The paraplegia patient who utilizes a mouth wand to function to any degree and where a mouth wand is inoperative because of missing natural teeth.
3) The spastic person whose manual dexterity precludes proper care and maintenance of a removable appliance.

Additional information and specific requirements for crowns under the Denti-Cal program may be found in Section 4 of the *Denti-Cal Provider Manual*. These and other questions may be addressed by phoning Denti-Cal toll-free at (800) 423-0507.

REVISED PAGES FOR THE PROVIDER MANUAL

An error has been found in the most recent update of the Provider Manual. Section 4. Pages 4-6 through 4-8 are missing. Please replace your current page 4-5 with the enclosed pages.

REVISED EDI SEMINAR INFORMATION

The EDI (Electronic Data Interchange) seminar scheduled for Friday, January 17, 2003 in Milpitas has been rescheduled. The seminar will now take place on

Friday, February 21, 2003

Crowne Plaza Hotel
777 Bellew Drive
Milpitas, California
(408) 321-9500

Registration: 8:30 am - 9:00 am
Presentation: 9:00 am - 12:00 pm

As seating is limited, please phone (800) 423-0507 to reserve a space.

REMINDER: UPCOMING SEMINARS

February 6, 2003	Basic Seminar/D893	Burbank
February 7, 2003	Advanced Seminar/D894	Burbank
February 27, 2003	Basic Seminar/D895	Escondido
February 28, 2003	Advanced Seminar/D896	Escondido

Check your Seminar Schedule (Denti-Cal Bulletin, Volume 18 # 25) for specifics!

For additional information regarding any of the above information, please telephone Denti-Cal toll-free at (800) 423-0507.

California Medi-Cal Dental Program

Denti-Cal Bulletin

VOLUME 19, NUMBER 3 P.O. BOX 15609 SACRAMENTO, CALIFORNIA 95852-0609 FEBRUARY 2003

DENTI-CAL'S INTERACTIVE VOICE RESPONSE (IVR) SYSTEM HAS BEEN MODIFIED

The Denti-Cal Interactive Voice System (IVR) has been changed to a touch-tone only system, effective March 4, 2003. Providers may continue to call Denti-Cal toll-free at (800) 423-0507 to access the following options: patient history, claim/Treatment Authorization Request (TAR) status, financial information, general Denti-Cal program information, and Denti-Cal enrollment status. If you know which key to press it is not necessary to listen to the complete message.

The IVR system for the beneficiary toll-free line has also been changed to a touch-tone only system. Beneficiaries may continue to call (800) 322-6384 to access information by touch-tone or to speak with a customer service representative Monday through Friday, 8:00 a.m. to 5:00 p.m., Pacific Standard Time (PST).

New Procedures for Entering Provider Identification When Requesting Patient History, Claim/TAR Status, Financial Information

To access the Denti-Cal provider phone system, you will need to enter the star key (*) followed by your Denti-Cal provider number. The following change has been made when entering the provider number using the touch-tone keypad for the above inquiries:

For provider numbers beginning with the letter B, press the star key (*), then the number 2 twice, followed by the remaining five numbers of your assigned provider number. For example, B12345 would be entered as *2-2-12345, followed with the two digit service office number, e.g. 01.

The system will need to recognize which alpha character you are trying to enter into the keypad. By pressing the number 2 key, you have told the system that your provider number begins with either A, B, or C. By pressing the number 2 key again, the system now recognizes that entry as a B, for the second letter on that key. These are also the same steps used when accessing the Automated Eligibility Verification System (AEVS).

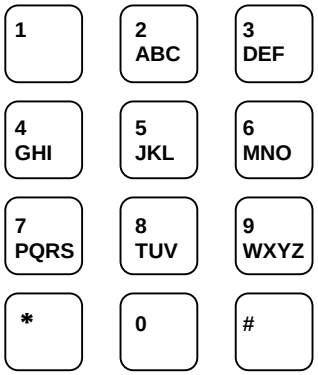
For provider numbers beginning with the letter G, press the star key (*), followed by the number 4 and then 1, and enter the remaining five numbers of your assigned provider number. For example, G12345 would be entered as *4-1-12345, followed with the two digit service office number, e.g. 01.

By pressing the number 4 key, you have told the system that your provider number begins with G, H, or I. By pressing the number 1, the system now recognizes that entry as a G, indicating the first letter on that key.

To assist you in entering alpha characters when using the IVR, each letter and its corresponding two-digit numeric code, always preceded by pressing the star key, is listed below.

Letter	Code	Letter	Code
A	*2-1	N	*6-2
B	*2-2	O	*6-3
C	*2-3	P	*7-1
D	*3-1	R	*7-2
E	*3-2	S	*7-3
F	*3-3	T	*8-1
G	*4-1	U	*8-2
H	*4-2	V	*8-3
I	*4-3	W	*9-1
J	*5-1	X	*9-2
K	*5-2	Y	*9-3
L	*5-3	Q	*1-1
M	*6-1	Z	*1-2

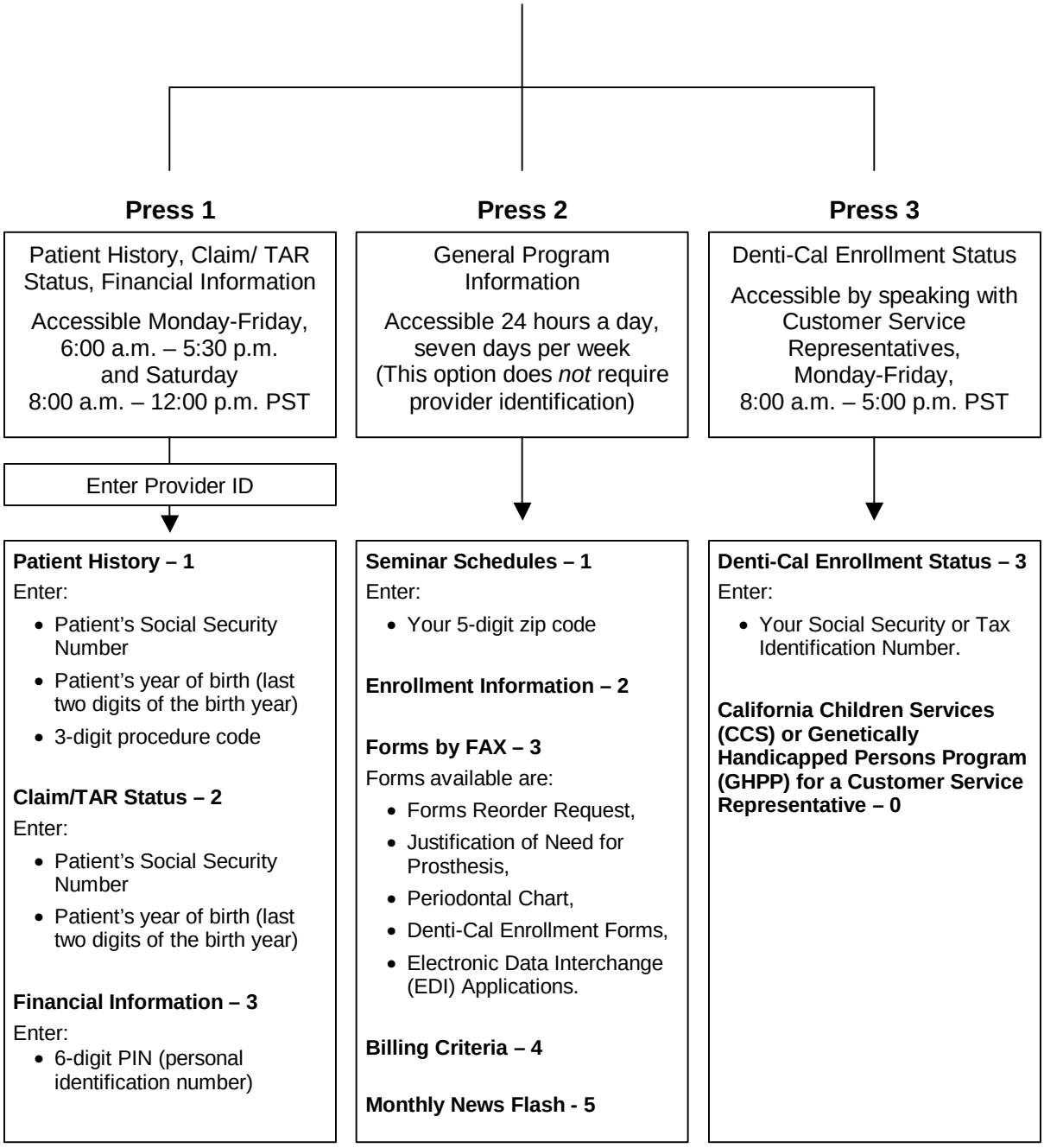
Remember to press ***** *before entering the two-digit code.*



NOTE: To check beneficiary eligibility, continue to use the Automated Eligibility Verification System (AEVS) by calling (800) 456-2387.

If you have any questions, please call Denti-Cal toll-free at (800) 423-0507.

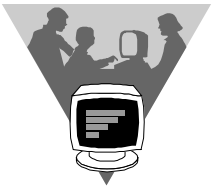
Provider Toll-Free Menu Options
(800) 423-0507



California Medi-Cal Dental Program

Denti-Cal Bulletin

VOLUME 19, NUMBER 4 P.O. BOX 15609 SACRAMENTO, CALIFORNIA 95852-0609 FEBRUARY 2003



Learn About Electronic Claims Submission!

ELECTRONIC DATA INTERCHANGE SEMINARS
Second Quarter Schedule

Electronic Data Interchange (EDI) seminars provide a general introduction to electronic claims submission and helpful tips for offices currently submitting claims electronically. These *FREE* presentations cover the advantages of EDI, how electronic claims are processed, how to best utilize electronic reports and other practical hints.

Second Quarter 2003 Seminar Schedule

DATE	CITY	TIME	LOCATION/PHONE NUMBER
May 9	Huntington Beach	1:00 p.m. to 4:00 p.m.	Meadowlark Golf Course & Club House 16782 Graham Street (714) 846-7416
May 16	South San Francisco	1:00 p.m. to 4:00 p.m.	San Francisco Convention Center 255 So. Airport Blvd. (650) 877-8787
June 20	Fresno	9:00 a.m. to noon	Four Points by Sheraton 3737 No. Blackstone (559) 230-8453

Seating is limited.
For reservations, please call Denti-Cal toll-free at (800) 423-0507.

Continuing education credits from the Academy of General Dentistry are available.

California Medi-Cal Dental Program

Denti-Cal Bulletin

VOLUME 19, NUMBER 5 P.O. BOX 15609 SACRAMENTO, CALIFORNIA 95852-0609 FEBRUARY, 2003

SEMINAR SCHEDULE FOR SECOND QUARTER, 2003

Basic Seminars

- Introduction to California Medi-Cal Dental Program
- Enrollment and Eligibility
- Proper Billing Procedures

Advanced Seminars

- Criteria Presented *by* a Dentist *for* Dentists and Staff
- View Actual Treatment Slides

Workshops

- Enrollment and Eligibility
- Criteria and Current Changes
- Hands-On Forms Completion
- HIPAA Informational Updates

Ortho Seminar

- Designed for Denti-Cal providers who limit their practices to orthodontics only
- Comprehensive information on certification, enrollment, billing procedures and criteria

ABOUT THE SEMINARS AND WORKSHOPS

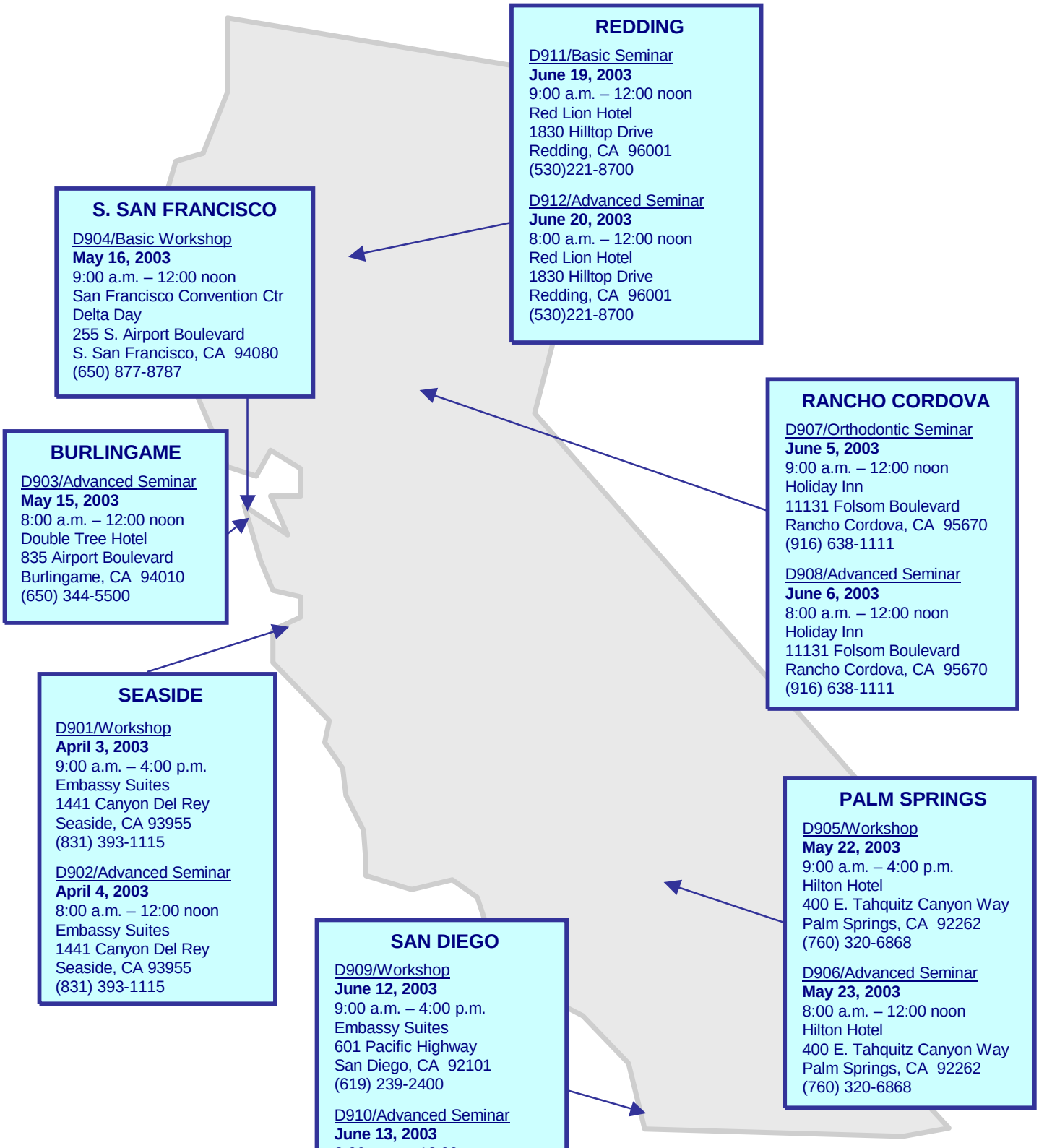
- ✓ Seminars and workshops are offered *free of charge*.
- ✓ Sessions begin *on time*, so arrive early.
- ✓ Bring your updated *Denti-Cal Provider Manual* to get the most from the training.
- ✓ Audio/video recording is not allowed.
- ✓ Billing information is subject to change.
- ✓ Reservations ensure that a space is available for you! Likewise, please let us know if you are unable to attend.
- ✓ Continuing education credits are available:

Basic Seminars	3 CE credits
Advanced Seminars	4 CE credits
Workshops	6 CE credits
Ortho Seminars	3 CE credits

- ✓ Some facilities may charge for parking.
- ✓ The use of cell phones during the seminar is strongly discouraged. If you must be available for calls, please be courteous and set the ringer on vibrate.

For additional information, questions and to register, please phone Denti-Cal toll free at 800/423-0507.

Denti-Cal Seminar Schedule
Second Quarter 2003



REDDING

D911/Basic Seminar
June 19, 2003
9:00 a.m. – 12:00 noon
Red Lion Hotel
1830 Hilltop Drive
Redding, CA 96001
(530)221-8700

D912/Advanced Seminar
June 20, 2003
8:00 a.m. – 12:00 noon
Red Lion Hotel
1830 Hilltop Drive
Redding, CA 96001
(530)221-8700

S. SAN FRANCISCO

D904/Basic Workshop
May 16, 2003
9:00 a.m. – 12:00 noon
San Francisco Convention Ctr
Delta Day
255 S. Airport Boulevard
S. San Francisco, CA 94080
(650) 877-8787

BURLINGAME

D903/Advanced Seminar
May 15, 2003
8:00 a.m. – 12:00 noon
Double Tree Hotel
835 Airport Boulevard
Burlingame, CA 94010
(650) 344-5500

RANCHO CORDOVA

D907/Orthodontic Seminar
June 5, 2003
9:00 a.m. – 12:00 noon
Holiday Inn
11131 Folsom Boulevard
Rancho Cordova, CA 95670
(916) 638-1111

D908/Advanced Seminar
June 6, 2003
8:00 a.m. – 12:00 noon
Holiday Inn
11131 Folsom Boulevard
Rancho Cordova, CA 95670
(916) 638-1111

SEASIDE

D901/Workshop
April 3, 2003
9:00 a.m. – 4:00 p.m.
Embassy Suites
1441 Canyon Del Rey
Seaside, CA 93955
(831) 393-1115

D902/Advanced Seminar
April 4, 2003
8:00 a.m. – 12:00 noon
Embassy Suites
1441 Canyon Del Rey
Seaside, CA 93955
(831) 393-1115

PALM SPRINGS

D905/Workshop
May 22, 2003
9:00 a.m. – 4:00 p.m.
Hilton Hotel
400 E. Tahquitz Canyon Way
Palm Springs, CA 92262
(760) 320-6868

D906/Advanced Seminar
May 23, 2003
8:00 a.m. – 12:00 noon
Hilton Hotel
400 E. Tahquitz Canyon Way
Palm Springs, CA 92262
(760) 320-6868

SAN DIEGO

D909/Workshop
June 12, 2003
9:00 a.m. – 4:00 p.m.
Embassy Suites
601 Pacific Highway
San Diego, CA 92101
(619) 239-2400

D910/Advanced Seminar
June 13, 2003
8:00 a.m. – 12:00 noon
Embassy Suites
601 Pacific Highway
San Diego, CA 92101
(619) 239-2400

DENTI-CAL PROVIDER TRAINING SEMINAR RESERVATION FORM

TYPE OF SEMINAR:

☐ Workshop
(Seminar Code Number:_____)

☐ Basic Seminar
(Seminar Code Number:_____)

☐ Advanced Seminar
(Seminar Code Number:_____)

☐ Ortho Seminar
(Seminar Code Number:_____)

Seating for all seminars is limited, so reserve your place today by returning this reservation form in the enclosed envelope to Denti-Cal. Be sure to include the seminar code number and indicate the names of staff who will be attending. Denti-Cal is unable to confirm your reservation by mail, so be sure to note the date and time on your calendar. ***To help us keep administrative costs down and continue to offer you free educational seminars, we request that you notify us in the event you need to cancel your reservation.***

PLEASE TYPE OR PRINT CLEARLY

Yes, I/my office staff wish to attend the Denti-Cal provider training seminar(s) indicated above. The name(s) of the person(s) attending are:

1._____ 4._____

2._____ 5._____

3._____ 6._____

In the area below, please type or print the dentist's name and office address:

_____ Provider No.:_____

_____

_____ Phone No.:_____

_____

California Medi-Cal Dental Program

Denti-Cal Bulletin

VOLUME 19, NUMBER 6 P.O. BOX 15609 SACRAMENTO, CALIFORNIA 95852-0609 MARCH 2003

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA) TRANSACTIONS AND CODE SETS: DENTI-CAL IMPLEMENTATION PLAN

Denti-Cal is making every effort to comply with HIPAA regulations, however, some of the HIPAA transactions and code sets projects will not meet the October 16, 2003 implementation deadline. The following information describes what components Denti-Cal will and will not implement by October 16, 2003. ***Providers must continue to follow existing billing instructions until otherwise notified through future bulletin updates.*** It is very important to review your monthly bulletins for more detailed instructions and implementation schedules related to HIPAA compliance.

Code Set Standards

HIPAA establishes standard codes for transactions. These standard codes include Current Dental Terminology version 4 (CDT-4) codes. Denti-Cal state-only or local codes currently applied within Denti-Cal will be phased out. Denti-Cal will notify providers, **submitting either paper or electronic transactions**, when it is acceptable to submit CDT-4 codes.

Denti-Cal anticipates changes for both electronic and paper billing submission requirements during the period of HIPAA implementation. These changes will continue to be communicated through regular provider bulletins. As future vehicles for communication are employed, providers will be notified.

Transaction Standards

Denti-Cal will implement the following standards as noted below and further described in subsequent paragraphs:

Transaction	Description	Standard Version	Implementation Date
* ASC X12N 837	Health Care Claims ▪ Dental	004010X097A1	October 2003
ASC X12N 835	Health Care Claim Payment/Advice	004010X091A1	After October 2003
ASC X12N 270/271	Health Care Eligibility Benefit Inquiry and Response	004010X092A1	Not applicable to Denti-Cal
ASC X12N 276/277	Health Care Claim Status Inquiry and Response	004010X093A1	October 2003

Transaction	Description	Standard Version	Implementation Date
ASCX12N 278	Health Care Services Review	004010X094A1	After October 2003
ASC X12N 820	Health Care Plan Payment		Not applicable to Denti-Cal Fee-for-service (FFS)
ASC X12N 834	Health Care Plan Enrollment		Not applicable to Denti-Cal FFS
ASC X12N 997	Functional Acknowledgement		Not a HIPAA mandated standard and will not be implemented at this time

* Accredited Standards Committee (ASC X12N)

Health Care Claims

Denti-Cal will begin accepting the 837 standard transaction (including Addenda) formats for Dental (X4010X097A1) claims by October 2003. Non-standard (proprietary) electronic claim formats will be phased out.

Remittance Advice (Health Care Claim Payment/Advice) for All Claim Types

Denti-Cal will begin generating the 835 004010X091A1 standard transaction (including Addenda) format for the claims remittance advice (Explanation of Benefits information) after October 2003. Providers who elect to receive an electronic remittance advice in the 835 standard transaction format will be able to download the remittance advice from the Connect:Mailbox after October 2003. In addition to the Adjustment Reason Codes required in the standard transaction format, Denti-Cal has elected to continue to provide a supplemental file that will contain an additional level of detail not provided by the standard transaction. This supplemental file will be provided as requested.

Health Care Eligibility Benefit Inquiry and Response

As Denti-Cal FFS does not currently perform the business function defined in the federal regulation for the 270/271 standard transaction, it is deemed not applicable and will not be implemented.

Health Care Claim Status Inquiry and Response

Denti-Cal will implement the 276/277 batch standard transaction formats (004010X093A1) (Claim Inquiry Form and Claim Inquiry Response) by October 2003. Non-standard (proprietary) electronic claim status inquiry and response formats will be phased out.

Health Care Services Review (Treatment Authorization Request - TAR)

Denti-Cal will not implement the 278 standard transaction format (004010X094A1) by October 2003. Non-standard (proprietary) electronic Treatment Authorization Request formats will be phased out, upon implementation of the standard transaction.

Health Care Plan Payment

As Denti-Cal FFS does not currently perform the business function defined in the federal regulation for the 820 standard transaction, it is deemed not applicable and will not be implemented.

Health Care Plan Enrollment

As Denti-Cal FFS does not currently perform the business function defined in the federal regulation for the 834 standard transaction, it is deemed not applicable and will not be implemented.

Functional Acknowledgment

The Functional Acknowledgment 997 transaction standard is not mandated under the HIPAA legislation, and will not be implemented by October 2003. If this status changes, it will be communicated in a future provider bulletin.

Testing

Denti-Cal is not currently prepared to accept or acknowledge test transactions from its trading partners. Activation for electronic billing and testing with select providers, submitters, vendors and clearinghouses is currently scheduled for late summer for the 276/277 and 837 transactions. Denti-Cal is not currently prepared to accept or acknowledge test transactions from its trading partners.

Technical Specifications (Companion Guides)

Currently, Denti-Cal draft technical specifications are being developed and will be made available upon completion. These drafts will be finalized in the testing phase scheduled for the June through September timeframe. The technical specifications or guides will be published in their final form by October 2003.

Frequently Asked Questions

For additional information regarding HIPAA, please refer to the following websites:

- www.medi-cal.ca.gov - Medi-Cal website
- www.dhs.cahwnet.gov/hipaa/ - Department of Health Services Office of HIPAA Compliance
- aspe.hhs.gov/admnsimp/ - Department of Health and Human Services

Direct emails to: DentiCal_HIPAA@delta.org. All emails will be responded to as quickly as possible.

California Medi-Cal Dental Program

Denti-Cal Bulletin

VOLUME 19, NUMBER 7 P.O. BOX 15609 SACRAMENTO, CALIFORNIA 95852-0609 MARCH 2003

MISUSE OF BENEFITS IDENTIFICATION CARD: NEW BICS ISSUED

Effective March 1, 2003, the Department of Health Services (DHS) Medical Review Branch is increasing the number of replacement Medi-Cal Benefits Identification Cards (BICs) in an ongoing effort to nullify BICs that may have been stolen or misused. Approximately 10,000 recipients per month will be issued BICs with new Identification (ID) numbers and issue dates. This process may be further escalated as other misuses of BICs are discovered.

When verifying eligibility for the recipients who receive new cards, the Automated Eligibility Verification System (AEVS) will return the eligibility message, "For claims payment, current BIC ID number and date of issue required." Providers must have and use the BIC ID number and issue date from the new card when verifying recipient eligibility. All providers must have and use the BIC ID number and issue date from the new card when submitting claims for reimbursement. If the BIC ID number and issue date of the new card are not on the claim for recipients whose card returns the message, "For claims payment, current BIC ID number and date of issue required," the claim will be denied.

A claim for payment on behalf of a recipient that returns the new eligibility message must include the new BIC ID number and issue date (mmddyy) as follows:

- Paper claims – new BIC ID in Patient Social Security Number (SSN) field (field 2) and new issue date in the Proof of Eligibility (POE) field;
- EDI claims – new BIC ID in SSN field and new issue date in the Comments field; and
- Attaching a copy of the BIC card for documentation purposes will not be accepted.

For assistance with obtaining eligibility information, please call the AEVS Help Desk at (800) 456-2387. For assistance with the POS device or the Medi-Cal Web site, call the POS/Internet Help Desk at (800) 427-1295. If illegal use of a BIC is suspected, or if you have any questions about this policy, call Provider Services at (800) 423-0507.

California Medi-Cal Dental Program

Denti-Cal Bulletin

VOLUME 19, NUMBER 8 P.O. BOX 15609 SACRAMENTO, CALIFORNIA 95852-0609 MARCH 2003

NEW ADJUDICATION REASON CODE FOR CLAIM INQUIRY FORM PROCESSING

When a Claim Inquiry Form (CIF) is submitted by the provider indicating that incorrect information was submitted on the original claim (e.g., tooth number, tooth surface(s), procedure code, date of service), the provider has six months from the date of the Explanation of Benefits (EOB) to request a reevaluation.

Denti-Cal will use the following adjudication reason code to inform the provider that the correct information was received and processed:

315 The correction(s) have been made based on the information submitted on the CIF. Payment cannot be made because the CIF was received over 6 months from the date of the EOB.

PROVIDERS TREATING BENEFICIARIES IN SKILLED NURSING FACILITIES (SNF) OR INTERMEDIATE CARE FACILIITIES (ICF)

It is important to include the name, address and phone number of the Skilled Nursing Facility (SNF) or Intermediate Care Facility (ICF) where a beneficiary resides when submitting Treatment Authorization Requests (TARs). Often the address provided is of the beneficiary's family address or of the conservator/guardian, rather than the facility. This incorrect information results in the Regional screener being unable to locate the beneficiary, which can cause treatment to be delayed or denied.

When this information is lacking, a Resubmission Turnaround Document (RTD) will be issued requesting the missing information. Should the RTD be returned without this information the TAR will be denied. Denti-Cal has modified the following RTD code 11 to read as follows:

RTD CODE 11 Submit beneficiary facility name/address/phone#.

VISIT DENTI-CAL AND ELECTRONIC DATA INTERCHANGE (EDI) BOOTHS AT ANAHEIM CALIFORNIA DENTAL ASSOCIATION (CDA) SCIENTIFIC SESSION

Be sure to visit the Denti-Cal and EDI booths at the CDA Scientific Session in Anaheim, Friday, April 25, 2003 through Sunday, April 27, 2003. Representatives from Denti-Cal's EDI program will be on-hand in booth number 735 with information and answers to your questions regarding electronic claims submission. You will find Denti-Cal Provider Relations staff in booth number 743, and Denti-Cal Outreach staff in booth number 745.

REMINDER: UPCOMING SEMINARS

Check your Seminar Schedule (Denti-Cal Bulletin, Volume 19 # 5) for details about seminars in your area.

EDI NEWS - ENROLLMENT INFORMATION

For an EDI Enrollment Packet, please contact Provider Services toll-free at (800) 423-0507. For an EDI How-To Guide or other information on submitting Denti-Cal claims and Treatment Authorization Requests (TARs) electronically, phone (916) 853-7373 and ask for EDI Support.

If you have additional questions, please call Denti-Cal toll-free at (800) 423-0507.

California Medi-Cal Dental Program

Denti-Cal Bulletin

VOLUME 19, NUMBER 9 P.O. BOX 15609 SACRAMENTO, CALIFORNIA 95852-0609 MARCH, 2003

NO CLAIM ACTIVITY FOR 12 MONTHS

The Welfare and Institutions Code states providers who have had no claim activity (submitting no claims or requesting reimbursement) in a twelve month period shall be deactivated. Welfare and Institutions Code Section 14043.62 reads as follows:

> The department shall deactivate, immediately and without prior notice, the provider numbers used by a provider to obtain reimbursement from the Medi-Cal program when warrants or documents mailed to a provider's mailing address or its pay to address, if any, or its service or business address, are returned by the United States Postal Service as not deliverable or when a provider has not submitted a claim for reimbursement from the Medi-Cal program for one year. Prior to taking this action the department shall use due diligence in attempting to contact the provider at its last known telephone number and ascertain if the return by the United States Postal Service is by mistake or shall use due diligence in attempting to contact the provider by telephone or in writing to ascertain whether the provider wishes to continue to participate in the Medi-Cal program. If deactivation pursuant to this section occurs, the provider shall meet the requirements for reapplication as specified in this article or the regulations adopted thereunder.

If you are deactivated and wish to re-enroll, please phone (800) 423-0507 to request an enrollment package. To remain in the Medi-Cal Program, please fill out the form below, stating why you wish to be an active provider. Send the form to: Denti-Cal, California Medi-Cal Dental Program, Post Office Box 15609, Sacramento, CA 95852-0609.

If you have any questions, please call Denti-Cal toll free at (800) 423-0507.

Yes, I wish to remain a provider in the California Medi-Cal Dental Program because _____

Check the boxes that apply to your practice:

- ☐ AAH (Alameda Alliance Health)
- ☐ CCS (California Children's Services)
- ☐ DMC (Dental Managed Care) Plan Name: _____
- ☐ FQHC/RHC (Federally Qualified Health Clinic/Rural Health Clinic)
- ☐ GHPP (Genetically Handicapped Persons Program)
- ☐ GMC (Geographic Managed Care) Plan Name: _____
- ☐ HFP (Healthy Families Program)

Provider Name/Number

Provider Signature

California Medi-Cal Dental Program

Denti-Cal Bulletin

VOLUME 19, NUMBER 10 P.O. BOX 15609 SACRAMENTO, CALIFORNIA 95852-0609 MARCH 2003

COMING SOON – MORE CHILDREN MAY COME TO YOUR PRACTICE THROUGH THE CHDP GATEWAY

What is CHDP?

The Child Health and Disability Prevention (CHDP) Program is a preventive health assessment program serving children and youth from low-income families. Eligible children include those:

- from birth to age 21 who are enrolled in Medi-Cal
- from birth to age 19 not receiving full-scope Medi-Cal from families with income up to 200% of the Federal Poverty Level.

A dental assessment by a medical provider is included in the CHDP program. The CHDP medical provider will refer children to a dentist for routine and follow-up dental treatment.

What is the CHDP Gateway?

Beginning July 1, 2003, CHDP medical providers (*not* dental providers) will be able to pre-enroll eligible low-income children under 19 years of age into a new program called the CHDP Gateway. These children will receive ***full-scope fee-for-service Medi-Cal and Denti-Cal benefits*** for up to two months. Some of these children may seek care from your office.

How is the CHDP Gateway relevant to my practice?

- More children will have access to comprehensive medical and dental coverage, resulting in their improved general and oral health.
- More children may be referred to your dental practice.
- The program offers you an opportunity to provide care to a group of children who might not otherwise have that opportunity.
- Because parents will know they may have less than 2 months to have as much of their child's dental treatment completed as possible, they should be more motivated to keep appointments.
- Medical providers and local CHDP program staff will be encouraging families to take advantage of care available to their children in a timely fashion.

How will the CHDP Gateway work?

- The medical provider's office will screen children for eligibility and will know within minutes if a child is eligible. If the child is eligible, the family will immediately receive an eligibility document while at the medical provider's office. Within 10 days, the child will receive a Benefits Identification Card (BIC) that can also be used to verify eligibility.

- The child will be temporarily eligible for Denti-Cal benefits for the remainder of the month in which they are pre-enrolled and for the following month. For example, a child determined eligible on July 15 would remain eligible through August 30.
- During the period of temporary eligibility, the family will be encouraged to apply for Medi-Cal/ Healthy Families coverage. If they do, the child's eligibility will be extended until the application is processed. If they do not, eligibility will end at the end of the second month.
- If the child is not currently under the care of a dentist, the family will be encouraged to make a dental appointment as soon as possible.
- The parent/caretaker will be instructed to bring the immediate eligibility document or BIC card with them to the child's dental appointment. You should still confirm the child's Medi-Cal eligibility at each visit. You will be able to refer the child for additional treatment to other fee-for-service Medi-Cal providers or have the child get a prescription filled.
- ***Because some children may be eligible for only 1-2 months, it is very important for children with temporary Medi-Cal eligibility to be seen as quickly as possible. You may want to consider setting aside a block of time to see these children.***

A more detailed Denti-Cal Bulletin about the CHDP Gateway will be issued closer to the July 1 start-up date. If you would like additional information about the program, please call your local CHDP program. A directory of local programs can be found at www.dhs.ca.gov/pcfh/cms/chdp/directory.htm.

California Medi-Cal Dental Program

Denti-Cal Bulletin

VOLUME 19, NUMBER 11 P.O. BOX 15609 SACRAMENTO, CALIFORNIA 95852-0609 APRIL 2003

CORRECT, COMPLETE INFORMATION LEADS TO SPEEDY PROCESSING OF PAPERWORK AND PAYMENT OF CLAIMS

SPECIFY CORRECT SERVICE OFFICE NUMBER

Documents received without a service office number or with an incorrect service office number listed, can delay the processing of claims and Treatment Authorization Requests (TARs) and increase the possibility that payment may be forwarded to the wrong office.

To ensure that claims, TARs and payments are processed correctly, please include the service office number along with your Medi-Cal billing provider number in field 20 on all forms. If you choose billing forms printed from your office computer, be sure that the system is set up to print correctly, reflecting the correct information.

SUBMISSION OF ATTACHMENTS

To prevent processing delays when sending an attachment to a paper claim, TAR, Notice of Authorization (NOA) Claim Inquiry Form (CIF) or Resubmission Turnaround Document (RTD) please follow these simple rules:

* when appropriate always use a Denti-Cal form (e.g. DC 054)
* include provider name, billing or rendered provider number, patient name and patient Medi-Cal identification (ID) number
* typewritten information on form or attachment is preferred
* attachment must be on a 8.5 x 11 piece of paper
* do not place attachment in the x-ray envelope
* place attachment behind the form and *staple just once* in the upper right hand corner
* do not send two-sided attachment

Other information such as operating room reports and physician statements should be provided on a separate piece of paper, attached to the form.

Electronic Data Interchange (EDI) providers should refer to their "How to Guide" for special instructions on submitting attachments associated with electronically submitted documents.

ONLY ORIGINALS OF CLAIM INQUIRY FORMS (CIFs) ARE ACCEPTABLE FOR PROCESSING

The CIF has two purposes: to inquire about the status of a previously submitted claim or TAR, or to request reevaluation of amodified or denied claim. *Denti-Cal will only accept original forms. No duplicates or photo copies will be accepted or processed*.

For your convenience these forms may be obtained, free of charge, from the Denti-Cal forms supplier. Please mail or fax your Forms Reorder Request Form (DC-004) using the information found below:

Shamrock Companies, Inc.
410 East Grantline Road
Tracy, CA 95376
fax: (209) 832-2105

PROVIDER MANUAL PURCHASERS SHOULD NOTIFY DENTI-CAL OF MAILING ADDRESS CHANGE

Please notify Denti-Cal as soon as possible when you have a change in address.

Denti-Cal Provider Manuals are being returned in large numbers due to undeliverable addresses. Effective immediately, Denti-Cal will remove names and addresses from the Provider Manual Purchasers List if the manuals are returned as undeliverable.

CORRECTION TO DENTI-CAL SEMINAR SCHEDULE - SECOND QUARTER 2003

An error was made in listing the seminar scheduled for May 16, 2003 in South San Francisco. Seminar D904 is listed as a "Basic Workshop" and should read "Basic Seminar." All other information is correct. We apologize for any confusion this may have caused.

REMINDER: UPCOMING SEMINARS

May 9, 2003	EDI Seminar	Huntingon Beach, CA
May 15, 2003	Advanced Seminar/D903	Burlingame, CA
May 16, 2003	Basic Seminar/D904	S. San Francisco, CA
May 16, 2003	EDI Seminar	S. San Francisco, CA
May 22, 2003	Workshop/D905	Palm Springs, CA
May 23, 2003	Advanced Seminar/D906	Palm Springs, CA

For specifics, check the Denti-Cal Seminar Schedules found in Volume 19, Numbers 4 and 5

For additional information please call Denti-Cal toll-free at (800) 423-0507.

California Medi-Cal Dental Program

Denti-Cal Bulletin

VOLUME 19, NUMBER 12 P.O. BOX 15609 SACRAMENTO, CALIFORNIA 95852-0609 MAY 2003

CHANGES IN COVERED BENEFITS AS SET FORTH IN SENATE BILL 26 (SBX1 26)

Effective July 1, 2003, the Department of Health Services will implement changes in covered benefits as set forth in Senate Bill 26 (SBX1 26), amending Welfare and Institutions Code Section 14132.88.

The Child Treatment Program (CTP) and County Medical Service Program (CMSP) are not subject to change at the present time.

RESTRICTION OF POSTERIOR LABORATORY PROCESSED CROWNS

Posterior laboratory processed crowns (procedures 650, 651, 652, 653, 660 and 663) will no longer be a benefit for adults 21 years of age and older except when a posterior tooth is used as an abutment for any fixed or removable prosthesis with cast clasps and rests, and meets current criteria. Providers must submit a radiograph or photograph to document an existing prosthesis.

Notices of Authorization will continue to be processed and mailed to providers up to and including June 30, 2003, however all crowns must be cemented prior to July 1, 2003 in order to be considered for payment. There will be no consideration for payment, full or partial, for undelivered crowns. ***If cemented July 1, 2003 or any date of service thereafter, payment cannot be made.***

Denti-Cal has created a new information code to indicate the need to cement the crown before the time frame for payment has expired:

386 This laboratory processed crown has been authorized; however, it must be cemented prior to July 1, 2003 to be considered for payment.

Denti-Cal has created a new adjudication reason code to assist in processing the Treatment Authorization Request (TAR):

113C Laboratory processed crowns are not a benefit for posterior teeth except for abutments for any fixed or removable prosthesis with cast clasps and rests. Please reevaluate for alternate treatment.

Denti-Cal has modified the following adjudication reason codes to assist in processing the Treatment Authorization Request (TAR):

113 Tooth does not meet manual of criteria requirements for laboratory processed crowns. Please reevaluate for alternate treatment.

113B Per x-rays, documentation or clinical evaluation, tooth is developmentally immature. Please reevaluate for alternate treatment.

PREFABRICATED CROWNS MADE FROM ADA-APPROVED MATERIALS

Prefabricated crowns will remain a benefit for posterior teeth. Beginning July 1, 2003, all services rendered for any prefabricated crown made from ADA-approved or certified materials used as a final restoration on posterior teeth will be reimbursed at the same rate as a stainless steel crown (procedures 670 or 671).

RATE REDUCTION FOR SUBGINGIVAL CURETTAGE AND ROOT PLANING

Effective for dates of service beginning July 1, 2003, the rate for subgingival curettage and root planing (procedure 452) shall be decreased from $200 to $118 for all beneficiaries with the exception of those residing in a Skilled Nursing Facility (SNF) or an Intermediate Care Facility (ICF) for the Developmentally Disabled. This rate includes those services with a Treatment Authorization Request (TAR) previously approved at the higher rate. The rate for beneficiaries residing in an SNF or ICF will not change.

For beneficiaries residing in an SNF or ICF, place of service fields 4, 5, or 8 must be indicated on the document in box 22, as explained in Section 3 of the Denti-Cal Provider Manual, in order to ensure payment at the correct rate. Place of service 4 or 5 should be indicated when treatment is performed in the SNF or ICF facility. Those providers treating an SNF or ICF beneficiary outside the facility in which they reside, either in a mobile van at the facility or in the provider's office, must indicate place of service 8 in box 22, as explained in Section 3 of the Denti-Cal Provider Manual. Providers must supply the beneficiary's SNF or ICF facility name, address and telephone number in box 34 (Comments). If any other place of service is indicated, or those fields are left blank, the reduced rate will be paid. Please note: beneficiaries who reside in an SNF or ICF will continue to be screened for medical necessity.

If you have additional questions, please call Denti-Cal toll-free at (800) 423-0507.

California Medi-Cal Dental Program

Denti-Cal Bulletin

VOLUME 19, NUMBER 13 P.O. BOX 15609 SACRAMENTO, CALIFORNIA 95852-0609 MAY 2003

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA)

This information is supplemental to the HIPAA updates provided in your March bulletin.

- ✓ ***Providers must continue to follow existing billing instructions until otherwise notified through future bulletin updates.***
- ✓ ***Current Dental Terminology (CDT) codes are not currently accepted by Denti-Cal and are considered invalid until such time as Department of Health Services adopts this coding standard.***
- ✓ ***Effective August 1, 2003, any claim service line (CSL) submitted with an invalid procedure code or a blank procedure code field will be denied, whether submitted electronically or as paper documents.***

Transactions and Code Sets

The compliance date for the transactions and code sets is October 16, 2003. Denti-Cal is making every effort to comply with HIPAA regulations, however some of the HIPAA transactions and code sets projects will not meet the October 16, 2003 implementation deadline. As information provided in this or future bulletins is supplemental to the original implementation strategy, schedule and timelines outlined in your March bulletin, *it is very important to retain and review all monthly bulletins for ongoing detailed instructions and implementation schedules related to HIPAA compliance.*

Code Sets

Use only Denti-Cal-approved local codes. Denti-Cal is changing the present system to comply with HIPAA regulations, although this has not yet been completed. This process involves replacing Denti-Cal three-digit, State approved four- and five-digit codes with the CDT codes only. Until further notice, the attached Denti-Cal Procedure Code Cross Reference Table and Denti-Cal Schedule of Maximum Allowances (SMA) should be used when submitting a Denti-Cal claim or Treatment Authorization Request (TAR).

For a denial of procedures of a dated CSL, a Claim Inquiry Form (CIF) will need to be submitted with valid procedure codes for payment consideration. Failure to submit a CIF with a valid procedure code will result in the CIF being denied. Make sure to include all applicable documentation and radiographs.

For a denial of procedures on a TAR, a reevaluation will need to be submitted with the valid procedure codes for consideration. Failure to submit a TAR for reevaluation with a valid procedure code will result in the TAR being denied. Make sure to include all applicable documentation and radiographs.

Privacy Rule

The final medical privacy portion of HIPAA became effective on April 14, 2003. Patient Rights under the Privacy Rules include:

- ✓ Right to adequate notice of Privacy Practices.
- ✓ Right to access their health information.
- ✓ Right to request the amendment of their health information.
- ✓ Right to an accounting of disclosures.
- ✓ Right to request the restriction of the uses and disclosures of their health information.
- ✓ Right to file a privacy complaint.
- ✓ Standards for privacy of individual's health data.

What Should Providers Be Doing?

EDI Providers

Ask your vendors, Information Technology Department and clearinghouses to see if, and when, they will be HIPAA compliant.

All Providers

- ✓ Read the Final Regulations, Implementation Guides and any other HIPAA material to understand the impact HIPAA will have on your organization.
- ✓ Assess your organization to determine what changes will need to happen to become HIPAA compliant.
- ✓ Involve your administrators, board of directors, operations, information systems, front and back office staff in the HIPAA awareness process.

Frequently Asked Questions

For additional information regarding HIPAA, please refer to the following websites:

- ✓ www.medi-cal.ca.gov - Medi-Cal website
- ✓ www.dhs.ca.gov/hipaa/ - Department of Health Services Office of HIPAA Compliance
- ✓ aspe.hhs.gov/admnsimp/ - Department of Health and Human Services

Direct emails to DentiCal_HIPAA@delta.org. All emails will be responded to as quickly as possible.

DENTI-CAL PROCEDURE CODE
CROSS REFERENCE TABLE

PROCEDURE CODE 3-DIGIT (DENTI-CAL)	PROCEDURE CODE 4-DIGIT (STATE-APPROVED)	PROCEDURE CODE 5-DIGIT (STATE-APPROVED)
010	9010	00100
015	9015	00120
020	9020	09430
030	9030	09440
035	9035	09425
040	9040	09310
045	9045	01352
046	9046	01353
047	9047	01354
049	9049	01120
050	9050	01110
061	9061	01201
062	9062	01202
080	9080	09110
110	9110	00220
111	9111	00230
112	9112	00210
113	9113	00240
114	9114	00250
115	9115	00260
116	9116	00272
117	9117	00274
118	9118	00270
119	9119	00475
120	9120	00476
125	9125	00330
150	9150	07286
160	9160	00450
200	9200	07110
201	9201	07120
202	9202	07210
203	9203	07255
204	9204	07256
220	9220	09930
230	9230	07220
231	9231	07230
232	9232	07240
250	9250	07320
252	9252	07310
255	9255	07340
256	9256	07341
257	9257	07470
258	9258	07471

PROCEDURE CODE 3-DIGIT (DENTI-CAL)	PROCEDURE CODE 4-DIGIT (STATE-APPROVED)	PROCEDURE CODE 5-DIGIT (STATE-APPROVED)
259	9259	07970
260	9260	07510
261	9261	07520
262	9262	07425
263	9263	07980
264	9264	07981
265	9265	07983
266	9266	07982
267	9267	07360
269	9269	07430
270	9270	07431
271	9271	07440
273	9273	07270
275	9275	07272
276	9276	07540
277	9277	07490
278	9278	07560
279	9279	07260
280	9280	07450
281	9281	07451
282	9282	07550
285	9285	07840
289	9289	07850
290	9290	07530
291	9291	07960
292	9292	07910
294	9294	07880
295	9295	07930
296	9296	07281
297	9297	07282
298	9298	07283
299	9299	07999
300	9300	09610
301	9301	09230
400	9400	09220
451	9451	04930
452	9452	04220
453	9453	04330
472	9472	04210
473	9473	04260
474	9474	04211
501	9501	03210
502	9502	03220
503	9503	03120
511	9511	03310

PROCEDURE CODE 3-DIGIT (DENTI-CAL)	PROCEDURE CODE 4-DIGIT (STATE-APPROVED)	PROCEDURE CODE 5-DIGIT (STATE-APPROVED)
512	9512	03320
513	9513	03330
530	9530	03420
531	9531	03410
534	9534	03350
550	9550	08855
551	9551	70551
552	9552	08856
554	9554	08857
556	9556	08858
557	9557	70557
558	9558	70558
562	9562	08356
564	9564	08357
570	9570	08455
572	9572	08456
580	9580	08555
582	9582	08556
590	9590	08955
592	9592	08956
594	9594	08957
596	9596	08758
598	9598	08959
599	9599	08750
600	9600	02110
601	9601	02120
602	9602	02130
603	9603	02131
611	9611	02140
612	9612	02150
613	9613	02160
614	9614	02161
640	9640	02210
641	9641	02211
645	9645	02310
646	9646	02335
648	9648	02334
650	9650	02710
651	9651	02720
652	9652	02740
653	9653	02750
660	9660	02790
663	9663	02810
670	9670	02830
671	9671	02831

PROCEDURE CODE 3-DIGIT (DENTI-CAL)	PROCEDURE CODE 4-DIGIT (STATE-APPROVED)	PROCEDURE CODE 5-DIGIT (STATE-APPROVED)
672	9672	02892
680	9680	06210
681	9681	06220
682	9682	06230
685	9685	02910
686	9686	02920
687	9687	06930
690	9690	06600
692	9692	06240
693	9693	06250
694	9694	06610
695	9695	06620
696	9696	06630
700	9700	05110
701	9701	05120
702	9702	05211
703	9703	05213
704	9704	05310
705	9705	06940
706	9706	05820
708	9708	05216
709	9709	05311
712	9712	05312
716	9716	05822
720	9720	05400
721	9721	05730
722	9722	05750
723	9723	05850
724	9724	05700
750	9750	05610
751	9751	05641
752	9752	05642
753	9753	05643
754	9754	05644
755	9755	05651
756	9756	05652
757	9757	05661
758	9758	05662
759	9759	05663
760	9760	05664
761	9761	05675
762	9762	05680
763	9763	05681
800	9800	01510
801	9801	01525

PROCEDURE CODE 3-DIGIT (DENTI-CAL)	PROCEDURE CODE 4-DIGIT (STATE-APPROVED)	PROCEDURE CODE 5-DIGIT (STATE-APPROVED)
802	9802	01526
811	9811	01511
812	9812	01515
832	9932	01530
900	9900	07610
901	9901	07620
902	9902	07630
903	9903	07640
904	9904	07720
905	9905	07710
906	9906	07740
907	9907	07730
913	9913	07830
915	9915	07660
916	9916	07750
950	9950	00115
952	9952	00116
955	9955	00322
956	9956	00340
957	9957	00341
960	9960	05901
962	9962	05902
964	9964	05903
966	9966	05904
968	9968	05905
970	9970	05910
971	9971	05911
972	9972	05914
975	9975	05918
976	9976	05930
977	9977	05931
978	9978	05925
979	9979	05926
980	9980	05927
981	9981	05928
982	9982	05929
985	9985	05939
990	9990	05980
992	9992	05981
994	9994	05982
995	9995	05995
996	9996	05984
998	9998	05985
999	9999	09999

California Medi-Cal Dental Program

Denti-Cal Bulletin

VOLUME 19, NUMBER 14 P.O. BOX 15609 SACRAMENTO, CALIFORNIA 95852-0609 MAY 2003

REMINDER: CLARIFICATION OF ADJUDICATION REASON CODE 274B

Adjudication Reason Code 274B reads as follows:

274 Comprehensive (full-mouth) treatment plan is required for consideration of services requested.

B Authorized treatment plan has been altered; therefore, payment is disallowed.

Please remember that *Procedures 700, 701 (full dentures), 702, 703, 706 and 708 (partial dentures) are authorized only as full treatment plans*. Approved Treatment Authorization Requests (TARs) are payable only when the full treatment has been completed. For example, when full upper and lower dentures have been authorized, payment is made when both procedures are completed and the Notice of Authorization (NOA) is submitted. *If, after receiving the authorization, the treatment plan changes and only one of the authorized appliances is delivered, Denti-Cal will disallow the request for payment of the delivered prosthetic appliance*. Again, any revision of an authorized treatment plan requires deletion of the existing Notice of Authorization (NOA) and submission of a new TAR with the revised treatment plan. *No treatment should be performed until the new TAR has been approved and the NOA has been received in your office*.

REMINDER: CLARIFICATION OF PAYMENT POLICY FOR REMOVABLE PROSTHETICS

California Code of Regulations, Title 22, Section 51008(b)(1)(B) states that the "month of service" for a dental prosthetic appliance procedure is the month in which the prosthesis was ordered from the fabricating laboratory. Providers must use the order date as the date of service when submitting for payment of an authorized removable prosthesis (procedures 700-706, 708, 709, 712 and 716). Should the beneficiary be required to pay a share-of-cost, the share-of-cost transaction must match the date the appliance was sent to the laboratory for final fabrication.

Providers who have had claims denied when using the date of insertion of the prosthesis may submit a Claim Inquiry Form (CIF) for reconsideration of payment. The CIF must include supporting documentation indicating the date the prosthesis was ordered.

REMINDER: DENTAL CRITERIA FOR BALANCE OF A COMPLETE DENTURE

The following defines balance and the criteria established for removable partial dentures under the Denti-Cal program:

Balance: A removable partial denture is covered only when necessary for the balance of a complete opposing denture. Balance is considered to be the presence of sufficient

occluding posterior teeth to afford satisfactory biomechanical support of a prosthetic appliance in all excursions of the mandible. A removable partial denture shall be considered necessary for the balance of a complete denture when, in the arch opposite the edentulous area, at least (excluding the third molars unless the third molar is occupying the position of the second molar and is in functional occlusion):

1. Four (4) adjacent natural posterior teeth are missing on the same side.
2. Three (3) adjacent natural posterior teeth are missing on the same side if the first bicuspid remains on the same side.
3. All four (4) natural permanent molars are missing.
4. Five (5) posterior permanent teeth are missing.

For additional information on dental criteria for balance of a complete denture, please refer to Section 6 – Glossary, of the *Denti-Cal Provider Manual*.

If you have additional questions, please call Denti-Cal toll-free at (800) 423-0507.

California Medi-Cal Dental Program

Denti-Cal Bulletin

VOLUME 19, NUMBER 15 P.O. BOX 15609 SACRAMENTO, CALIFORNIA 95852-0609 MAY 2003

SEMINAR SCHEDULE FOR THIRD QUARTER, 2003

Basic Seminars

- Introduction to California Medi-Cal Dental Program
- Enrollment and Eligibility
- Proper Billing Procedures

Advanced Seminars

- Criteria Presented *by* a Dentist *for* Dentists and Staff
- View Actual Treatment Slides

Workshops

- Enrollment and Eligibility
- Criteria and Current Changes
- Hands-On Forms Completion
- HIPAA Informational Updates

ABOUT THE SEMINARS AND WORKSHOPS

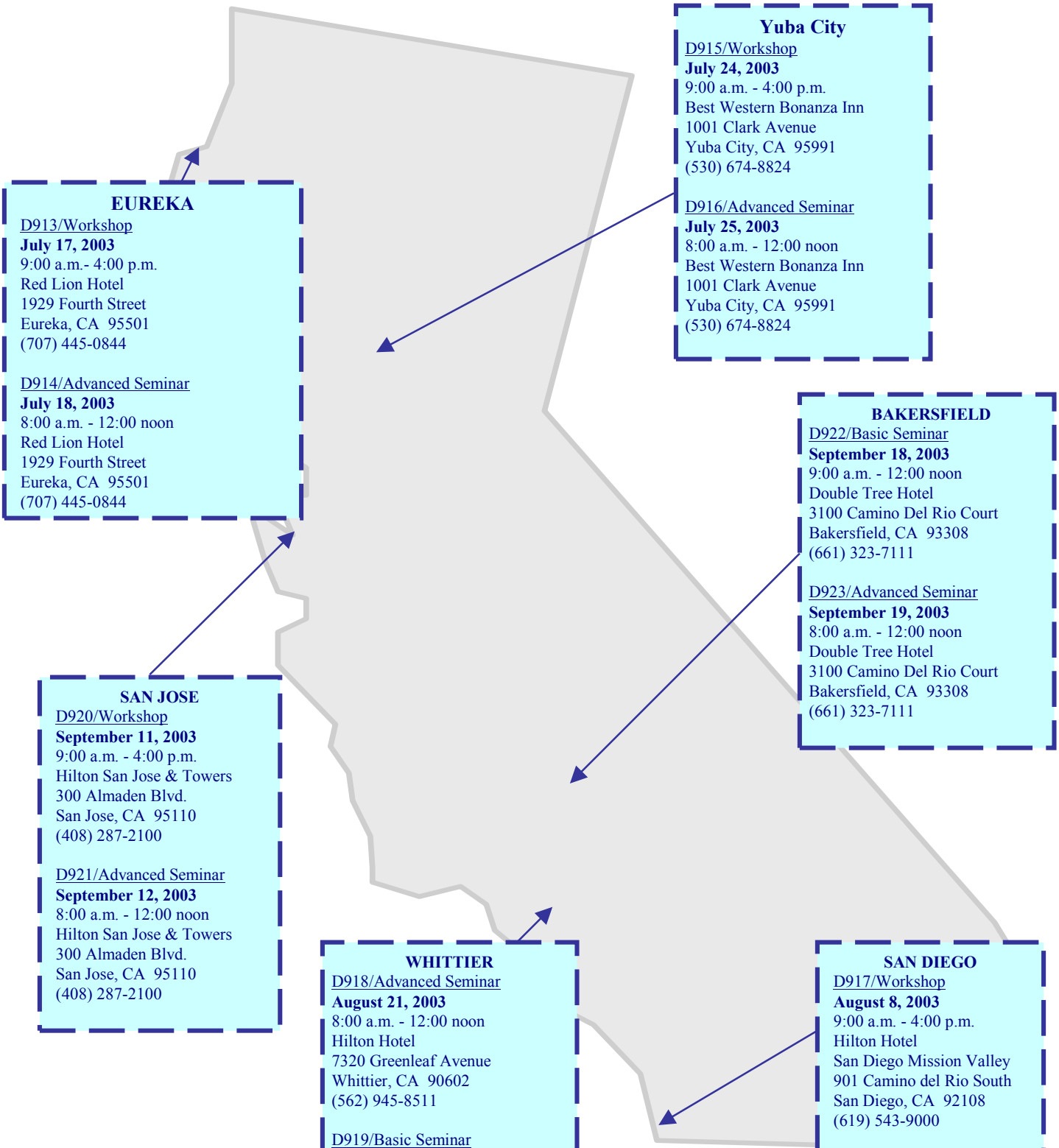
- ✓ Seminars and workshops are offered *free of charge*.
- ✓ Sessions begin *on time*, so arrive early.
- ✓ Bring your updated *Denti-Cal Provider Manual* to get the most from the training.
- ✓ Audio/video recording is not allowed.
- ✓ Billing information is subject to change.
- ✓ Reservations ensure that a space is available for you! Likewise, please let us know if you are unable to attend.
- ✓ Continuing education credits are available:

Basic Seminars	3 CE credits
Advanced Seminars	4 CE credits
Workshops	6 CE credits

- ✓ Some facilities may charge for parking.
- ✓ The use of cell phones during the seminar is strongly discouraged. If you must be available for calls, please be courteous and set the ringer on vibrate.

For additional information, questions and to register, please phone Denti-Cal toll free at 800/423-0507.

Denti-Cal Seminar Schedule
Third Quarter 2003



EUREKA
D913/Workshop
July 17, 2003
9:00 a.m.- 4:00 p.m.
Red Lion Hotel
1929 Fourth Street
Eureka, CA 95501
(707) 445-0844

D914/Advanced Seminar
July 18, 2003
8:00 a.m. - 12:00 noon
Red Lion Hotel
1929 Fourth Street
Eureka, CA 95501
(707) 445-0844

Yuba City
D915/Workshop
July 24, 2003
9:00 a.m. - 4:00 p.m.
Best Western Bonanza Inn
1001 Clark Avenue
Yuba City, CA 95991
(530) 674-8824

D916/Advanced Seminar
July 25, 2003
8:00 a.m. - 12:00 noon
Best Western Bonanza Inn
1001 Clark Avenue
Yuba City, CA 95991
(530) 674-8824

BAKERSFIELD
D922/Basic Seminar
September 18, 2003
9:00 a.m. - 12:00 noon
Double Tree Hotel
3100 Camino Del Rio Court
Bakersfield, CA 93308
(661) 323-7111

D923/Advanced Seminar
September 19, 2003
8:00 a.m. - 12:00 noon
Double Tree Hotel
3100 Camino Del Rio Court
Bakersfield, CA 93308
(661) 323-7111

SAN JOSE
D920/Workshop
September 11, 2003
9:00 a.m. - 4:00 p.m.
Hilton San Jose & Towers
300 Almaden Blvd.
San Jose, CA 95110
(408) 287-2100

D921/Advanced Seminar
September 12, 2003
8:00 a.m. - 12:00 noon
Hilton San Jose & Towers
300 Almaden Blvd.
San Jose, CA 95110
(408) 287-2100

WHITTIER
D918/Advanced Seminar
August 21, 2003
8:00 a.m. - 12:00 noon
Hilton Hotel
7320 Greenleaf Avenue
Whittier, CA 90602
(562) 945-8511

D919/Basic Seminar
August 22, 2003
DELTA DAY
9:00 a.m. - 12:00 noon
Hilton Hotel
7320 Greenleaf Avenue
Whittier, CA 90602
(562) 945-8511

SAN DIEGO
D917/Workshop
August 8, 2003
9:00 a.m. - 4:00 p.m.
Hilton Hotel
San Diego Mission Valley
901 Camino del Rio South
San Diego, CA 92108
(619) 543-9000

DENTI-CAL PROVIDER TRAINING SEMINAR RESERVATION FORM

TYPE OF SEMINAR:

☐ Workshop
(Seminar Code Number:_____)

☐ Basic Seminar
(Seminar Code Number:_____)

☐ Advanced Seminar
(Seminar Code Number:_____)

Seating for all seminars is limited, so reserve your place today by returning this reservation form in the enclosed envelope to Denti-Cal. Be sure to include the seminar code number and indicate the names of staff who will be attending. Denti-Cal is unable to confirm your reservation by mail, so be sure to note the date and time on your calendar. ***To help us keep administrative costs down and continue to offer you free educational seminars, we request that you notify us in the event you need to cancel your reservation.***

PLEASE TYPE OR PRINT CLEARLY

Yes, I/my office staff wish to attend the Denti-Cal provider training seminar(s) indicated above. The name(s) of the person(s) attending are:

1._____ 4._____

2._____ 5._____

3._____ 6._____

In the area below, please type or print the dentist's name and office address:

_____ Provider No.:_____

_____

_____ Phone No.:_____

_____

California Medi-Cal Dental Program

Denti-Cal Bulletin

VOLUME 19, NUMBER 16 P.O. BOX 15609 SACRAMENTO, CALIFORNIA 95852-0609 MAY 2003

Learn About Electronic Claims Submission!

ELECTRONIC DATA INTERCHANGE SEMINARS
Third Quarter Schedule

Electronic Data Interchange (EDI) seminars provide a general introduction to electronic claims submission and helpful tips for offices currently submitting claims electronically. These *FREE* presentations cover the advantages of EDI, how electronic claims are processed, how to best utilize electronic reports and other practical hints.

Third Quarter 2003 Seminar Schedule

DATE	CITY	TIME	LOCATION/PHONE NUMBER
July 18	Carlsbad	1:00 p.m. to 4:00 p.m.	Holiday Inn Carlsbad-by-the-Sea 850 Palomar Airport Road (760) 438-7880
August 22	Whittier	1:00 p.m. to 4:00 p.m.	Whittier Hilton 7320 Greenleaf Avenue (562) 945-8511
September 12	Napa	9:00 a.m. to noon	Embassy Suites 1075 California Boulevard (707) 253-9540

Seating is limited.
For reservations, please call Denti-Cal toll-free at (800) 423-0507.

Continuing education credits from the Academy of General Dentistry are available.

California Medi-Cal Dental Program

Denti-Cal Bulletin

VOLUME 19, NUMBER 17 P.O. BOX 15609 SACRAMENTO, CALIFORNIA 95852-0609 JUNE 2003

CHANGES IN COVERED BENEFITS AS SET FORTH IN SENATE BILL 26 (SBX1 26)

Effective July 1, 2003, the Department of Health Services will implement changes in covered benefits as set forth in Senate Bill 26 (SBX1 26), amending Welfare and Institutions Code Section 14132.88.

Effective August 1, 2003, the Department of Health Services will implement changes in covered benefits as set forth in Senate Bill 26 (SBX1 26), amending Welfare and Institutions Code Section 14132.88 for the Child Treatment Program (CTP).

The County Medical Services Program (CMSP) is not subject to change at the present time.

RESTRICTION OF POSTERIOR LABORATORY PROCESSED CROWNS

Posterior laboratory processed crowns (procedures 650, 651, 652, 653, 660 and 663) will no longer be a benefit for adults 21 years of age and older except when a posterior tooth is used as an abutment for any fixed or removable prosthesis with cast clasps and rests, and meets current criteria. Providers must submit a radiograph or photograph to document an existing prosthesis. This includes prefabricated crown procedures for all bicuspids and molars.

Notices of Authorization will continue to be processed and mailed to providers up to and including June 30, 2003, however all crowns must be cemented prior to July 1, 2003 in order to be considered for payment. There will be no consideration for payment, full or partial, for undelivered crowns. ***If cemented July 1, 2003 or any date of service thereafter, payment cannot be made and will be disallowed using the following adjudication reason code:***

263 Procedure requested is not a benefit for adults.

Denti-Cal has created a new information code to indicate the need to cement the crown before the time frame for payment has expired:

386 This laboratory processed crown has been authorized; however, it must be cemented prior to July 1, 2003 to be considered for payment.

Denti-Cal has created a new adjudication reason code to assist in processing the Treatment Authorization Request (TAR):

113C Laboratory processed crowns are not a benefit for posterior teeth except for abutments for any fixed or removable prosthesis with cast clasps and rests. Please reevaluate for alternate treatment.

Denti-Cal has modified the following adjudication reason codes to assist in processing the Treatment Authorization Request (TAR):

113 Tooth does not meet manual of criteria requirements for laboratory processed crowns. Please reevaluate for alternate treatment.

113B Per x-rays, documentation or clinical evaluation, tooth is developmentally immature. Please reevaluate for alternate treatment.

PREFABRICATED CROWNS MADE FROM ADA-APPROVED MATERIALS

On May 5, 2003, Senate Bill 26 (SBX1 26) was signed into law and amends Welfare and Institutions Code Section 14132.88. The language of this legislative bill reads:

> "For persons 21 years of age or older, laboratory-processed crowns on posterior teeth are not a covered benefit except when a posterior tooth is necessary as an abutment for any fixed or removable prosthesis.
>
> "Any prefabricated crown made from ADA-approved materials may be used on posterior teeth and may be reimbursed as a stainless steel crown."

Effective July 1, 2003, the Department of Health Services will implement changes as mentioned above in the following fashion:

Prefabricated crowns will remain a benefit for posterior teeth. Beginning July 1, 2003, all services rendered for *any* prefabricated crowns used as a final restoration on posterior teeth -- ADA-approved or certified materials, open faced stainless steel crowns, and/or open faced stainless steel crowns with resin -- should be submitted and will be reimbursed at the same rate as a stainless steel crown using procedures 670 or 671. This will remain in effect until Current Dental Terminology (CDT) codes are implemented for Denti-Cal.

RATE REDUCTION FOR SUBGINGIVAL CURETTAGE AND ROOT PLANING

Effective for dates of service beginning July 1, 2003, the rate for subgingival curettage and root planing (procedure 452) shall be decreased from $200 to $118 for all beneficiaries with the exception of those residing in a Skilled Nursing Facility (SNF) or an Intermediate Care Facility (ICF) for the Developmentally Disabled. This rate includes those services with a Treatment Authorization Request (TAR) previously approved at the higher rate. The rate for beneficiaries residing in an SNF or ICF will not change.

For beneficiaries residing in an SNF or ICF, place of service fields 4, 5, or 8 must be indicated on the document in box 22, as explained in Section 3 of the Denti-Cal Provider Manual, in order to ensure payment at the correct rate. Place of service 4 or 5 should be indicated when treatment is performed in the SNF or ICF facility. Those providers treating an SNF or ICF beneficiary outside the facility in which they reside, either in a mobile van at the facility or in the provider's office, must indicate place of service 8 in box 22, as explained in Section 3 of the Denti-Cal Provider Manual. Providers must supply the beneficiary's SNF or ICF facility name, address, and telephone number in box 34 (Comments). If any other place of service is indicated, or those fields are left blank, the reduced rate will be paid. Please note: beneficiaries who reside in an SNF or ICF will continue to be screened for medical necessity.

If you have additional questions, please call Denti-Cal toll-free at (800) 423-0507.

California Medi-Cal Dental Program

Denti-Cal Bulletin

VOLUME 19, NUMBER 18 P.O. BOX 15609 SACRAMENTO, CALIFORNIA 95852-0609 JUNE 2003

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA)

This information is supplemental to the HIPAA updates provided in your March bulletin.

- ✓ ***Providers must continue to follow existing billing instructions until otherwise notified through future bulletin updates.***
- ✓ ***Current Dental Terminology (CDT) codes are not currently being accepted by Denti-Cal and are considered invalid until such time as Department of Health Services adopts this coding standard.***
- ✓ ***Effective August 1, 2003, any Claim Service Line (CSL) submitted with an invalid procedure code or a blank procedure code field will be denied, whether submitted electronically or as paper documents.***

Code Sets

Use only Denti-Cal-approved local codes. Denti-Cal is changing the present system to comply with HIPAA regulations and this is not yet completed. This process involves replacing Denti-Cal three-digit, State approved four- and five-digit codes with the CDT codes only. Until further notice, use only the Denti-Cal Procedure Code Cross Reference Table and the Denti-Cal Schedule of Maximum Allowances (SMA) when submitting a Denti-Cal claim or Treatment Authorization Request (TAR).

For a denial of procedures of a dated CSL, a Claim Inquiry Form (CIF) will need to be submitted with valid procedure codes for payment consideration. Failure to submit a CIF with a valid procedure code will result in the CIF being denied. Make sure to include all applicable documentation and radiographs.

For a denial of procedures on a TAR, a reevaluation will need to be submitted with the valid procedure codes for consideration. Failure to submit a TAR for reevaluation with a valid procedure code will result in the TAR being denied. Make sure to include all applicable documentation and radiographs.

Release of Beneficiary Information

Denti-Cal is frequently required to request information from its providers in a variety of circumstances, such as:

- ✓ When a duplicate TAR is received. Denti-Cal will then need to call the provider's office to determine if authorized services have been performed.
- ✓ When Denti-Cal is using its authority to conduct provider compliance audits.
- ✓ When Denti-Cal is resolving beneficiary treatment history conflicts.

The circumstances identified above are included in the HIPAA Privacy Rule (CFR Section 164.506(c)(4)) under treatment, payment and healthcare operations (TPO) and are specifically allowed without an authorization from the beneficiary. The rule states that "A covered entity may disclose protected health information to another covered entity for health care operations activities of the entity that receives the information, if each entity either has or had a relationship with the individual who is the subject of the protected health information being requested, the protected health information pertains to such relationship…."

Direct emails to DentiCal_HIPAA@delta.org. All emails will be responded to as quickly as possible.

California Medi-Cal Dental Program

Denti-Cal Bulletin

VOLUME 19, NUMBER 19 P.O. BOX 15609 SACRAMENTO, CALIFORNIA 95852-0609 JUNE 2003

NEW AID CODES 1E, 2E AND 6E

These codes are as a result of the June 24, 2002 court ruling in the Craig v. Bonta lawsuit, when the Department of Health Services was ordered to stop terminating SSI/SSP-linked Medi-Cal for persons who lose SSI/SSP benefits after May 2002. In order to comply with that court order, three aid codes are needed to identify the affected population and to provide benefits until a proper redetermination of eligibility is completed.

Recipients in aid code 1E will be eligible for full scope benefits with no share of cost, valid for the Local Education Agency Medi-Cal Billing option program, the Child Health Disability Prevention program, and are inclusive for baby on mom's ID. The eligibility message will be "Continued Eligibility for the Aged."

Recipients in aid codes 2E will be eligible for full scope benefits with no share of cost, valid for the Local Education Agency Medi-Cal Billing option program, the Child Health Disability Prevention program, and are inclusive for baby on mom's ID. The eligibility message will be "Continued Eligibility for the Blind."

Recipients in aid code 6E will be eligible for full scope benefits with no share of cost, valid for the Local Education Agency Medi-Cal Billing option program, the Child Health Disability Prevention program, and are inclusive for baby on mom's ID. The eligibility message will be "Continued Eligibility for the Disabled."

1E Craig v. Bonta Continued Eligibility for the Aged. Aid code 1E covers former SSI beneficiaries who are aged (with the exception of persons who are deceased or incarcerated in a correctional facility) until the county redetermines their Medi-Cal eligibility. Provides fee-for-service full scope Medi-Cal without a share of cost and with federal financial participation.

2E Craig v. Bonta Continued Eligibility for the Blind. Aid code 2E covers former SSI beneficiaries who are blind (with the exception of persons who are deceased or incarcerated in a correctional facility) until the county redetermines their Medi-Cal eligibility. Provides fee-for-service full scope Medi-Cal without a share of cost and with federal financial participation.

6E Craig v. Bonta Continued Eligibility for the Disabled. Aid code 6E covers former SSI beneficiaries who are disabled (with the exception of persons who are deceased or incarcerated in a correctional facility) until the county redetermines their Medi-Cal eligibility. Provides fee-for-service full scope Medi-Cal without a share of cost and with federal financial participation.

NEW AID CODES 1X AND 1Y: MULTIPURPOSE SENIOR SERVICES PROGRAM WAIVER

These codes are as a result of the Department of Aging Multipurpose Senior Services Program (MSSP) waiver amendment to allow for transitional services that were provided in an institution to support the de-institutionalization of a Medi-Cal individual once the individual leaves the institution. Additionally, these aid codes will allow the county to determine eligibility using special institutional deeming rules (spousal impoverishment) for a person who moves from the institution and returns home to their spouse, or for a person who is already living in the community.

Recipients in aid code 1X will be eligible for full scope benefits with no share of cost. The eligibility message will be "Multipurpose Senior Services Program - No SOC."

Recipients in aid code 1Y will be eligible for full scope benefits with a share of cost. The eligibility message will be "Multipurpose Senior Services Program - with SOC."

1X Multipurpose Senior Services Program waiver provides full scope benefits, MMSP transitional and non-transitional services, with no share of cost and with federal financial participation.

1Y Multipurpose Senior Services Program waiver provides full scope benefits, MSSP transitional and non-transitional services, with a share of cost and with federal financial participation.

HELPFUL HINTS TO ENSURE SPEEDY PROCESSING OF CLAIMS AND TREATMENT AUTHORIZATION REQUESTS (TARs)

Before submitting either a claim for payment or a TAR for processing, verify that *all* necessary information is included, submitting sufficient description and detail to ensure prompt approval and the expediting of payment for services rendered.

The following list pinpoints areas on these and other forms where information is most frequently missing:

- ✓ list teeth to be replaced and/or clasped,
- ✓ tooth number, letter, arch or quadrant (box 26),
- ✓ surfaces (box 27),
- ✓ description of service including x-rays, prophylaxis and materials used (box 28),
- ✓ date of service (box 29),
- ✓ procedure number (box 31),
- ✓ fee (box 32), and
- ✓ the rendering provider's Medi-Cal provider number (box 33).

Submission of incomplete forms may result in processing and payment delays, possibly requiring that Denti-Cal send a Resubmission Turnaround Document (RTD).

REMINDER: BILLING LIMITATIONS FOR PROCEDURES 110 AND 111

Under the Denti-Cal program, during a 12-month period providers may bill a maximum of 20 intraoral periapical x-rays (procedures 110/111) for an individual patient. If a provider submits a claim for procedures 110 and/or 111 and patient history indicates the provider has already billed for the maximum within the last 12 months, the procedures will be denied with adjudication reason code 030D, which reads as follows:

> **030D** An adjustment has been made for the maximum allowable x-rays. Procedures 110/111 limited to 20 in any consecutive 12-month period.

As a reminder all other criteria for billing x-ray procedures still apply. Please refer to the Manual of Criteria in Section 4 of your *Denti-Cal Provider Manual* for the policies governing x-ray procedures.

If you have additional questions, please call Denti-Cal toll-free at (800) 423-0507.

California Medi-Cal Dental Program

Denti-Cal Bulletin

VOLUME 19, NUMBER 20 P.O. BOX 15609 SACRAMENTO, CALIFORNIA 95852-0609 JUNE, 2003

NO CLAIM ACTIVITY FOR 12 MONTHS

The Welfare and Institutions Code states providers who have had no claim activity (submitting no claims or requesting reimbursement) in a twelve month period shall be deactivated. Welfare and Institutions Code Section 14043.62 reads as follows:

> The department shall deactivate, immediately and without prior notice, the provider numbers used by a provider to obtain reimbursement from the Medi-Cal program when warrants or documents mailed to a provider's mailing address or its pay to address, if any, or its service or business address, are returned by the United States Postal Service as not deliverable or when a provider has not submitted a claim for reimbursement from the Medi-Cal program for one year. Prior to taking this action the department shall use due diligence in attempting to contact the provider at its last known telephone number and ascertain if the return by the United States Postal Service is by mistake or shall use due diligence in attempting to contact the provider by telephone or in writing to ascertain whether the provider wishes to continue to participate in the Medi-Cal program. If deactivation pursuant to this section occurs, the provider shall meet the requirements for reapplication as specified in this article or the regulations adopted thereunder.

If you are deactivated and wish to re-enroll, please phone (800) 423-0507 to request an enrollment package. To remain in the Medi-Cal Program, please fill out the form below, stating why you wish to be an active provider. Send the form to: Denti-Cal, California Medi-Cal Dental Program, Post Office Box 15609, Sacramento, CA 95852-0609.

If you have any questions, please call Denti-Cal toll free at (800) 423-0507.

Yes, I wish to remain a provider in the California Medi-Cal Dental Program because _____

_____

Check the boxes that apply to your practice:

- ☐ AAH (Alameda Alliance Health)
- ☐ CCS (California Children's Services)
- ☐ DMC (Dental Managed Care) Plan Name: _____
- ☐ FQHC/RHC (Federally Qualified Health Clinic/Rural Health Clinic)
- ☐ GHPP (Genetically Handicapped Persons Program)
- ☐ GMC (Geographic Managed Care) Plan Name: _____
- ☐ HFP (Healthy Families Program)

_____ _____

Provider Name/Number Provider Signature

California Medi-Cal Dental Program

Denti-Cal Bulletin

VOLUME 19, NUMBER 21 P.O. BOX 15609 SACRAMENTO, CALIFORNIA 95852-0609 JULY 2003

CHANGES IN THE SUBMISSION REQUIREMENTS FOR MEDI-CAL DENTAL CLAIMS FOR RESTORATIVE PROCEDURES AS SET FORTH IN SENATE BILL 26 (SBX1 26) AMENDING THE WELFARE AND INSTITUTIONS CODE 14132.88

Effective for dates of service September 1, 2003 and after, the Department of Health Services will require that all Medi-Cal Dental claims for restorative procedures (600, 601, 602, 603, 611, 612, 613, 614, 645, 646, 670 and 671) must include the submission of radiographs and/or photographs that clearly demonstrate that destruction to the tooth (decay, fracture, missing restorations, et cetera) extends through the dentinoenamel junction (DEJ). There must be **visual evidence** of damage impinging upon the DEJ depicted on the radiograph or photograph in order for payment to be made for the restoration. These requirements are in addition to existing criteria for these procedures.

In the event that the submitted radiographs do not adequately demonstrate this degree of destruction, providers are required to submit an intraoral photograph visually showing the condition. **Other forms of documentation, such as written comments, patient records, or explanatory notes will not be acceptable. The statement "Caries through DEJ" will no longer be considered adequate documentation for payment of a restoration**. Entire restorations or individual surfaces of restorations will be denied when the submitted radiographs and/or intraoral photographs do not adequately demonstrate that the destruction impinges upon the DEJ. The need to replace existing restorations due to recurrent decay, fracture, or loss, must also be supported by radiographs and/or photographs. **If no radiograph or photograph is attached, the restorative procedures will be denied automatically.**

If bitewing radiographs are submitted and the destruction appears to encroach upon the pulp, a periapical radiograph demonstrating the apex/apices of the tooth must be submitted.

These new submission requirements will apply for both children and adult beneficiaries of the Medi-Cal Dental Program. County Medical Services Program (CMSP) and Children's Treatment Program (CTP) claims are excluded from this policy change at this time. Services provided to children by Board Certified Pediatric Dentists are also excluded from this requirement.

Submitted radiographs and photographs must conform to the existing requirements and must be:

- ✓ dated and labeled legibly with the patient's name and Social Security number or Benefits Identification Card number, as well as the Provider's name and Medi-Cal provider number;
- ✓ current (taken within the last 14 months);
- ✓ diagnostic quality;
- ✓ labeled "right" and "left"; and
- ✓ submitted in appropriate Denti-Cal mailing envelopes.

In addition:

- ✓ radiographs in multiples of four or more must be mounted; and
- ✓ photographs must have the tooth numbers clearly identified.

If radiographs and/or photographs are NOT to be returned, indicate "do not return" on the envelope.

If you have any questions, please call Denti-Cal toll-free at (800) 423-0507.

California Medi-Cal Dental Program

Denti-Cal Bulletin

VOLUME 19, NUMBER 22 P.O. BOX 15609 SACRAMENTO, CALIFORNIA 95852-0609 JULY 2003

REDEFINITION OF AID CODES 3A AND 3C

These codes were previously used for the California Alternative Assistance Program (CAAP) where participants who were eligible for a cash grant had declined that cash grant. These participants received childcare and Denti-Cal as part of the CAAP. Assembly Bill 67, Chapter 606, Statutes of 1997 repealed the CAAP on October 3, 1997. The full scope, no Share of Cost benefits under these aid codes remain the same.

3A Safety Net - All Other Families, CalWORKs, Timed-Out, Child-Only Case. This program provides for continued cash and Denti-Cal coverage of children whose parents have been discontinued from cash aid and removed from the assistance unit (AU) due to reaching the CalWORKs 60-month time limit without meeting a time extender exception.

3C Safety Net - Two-Parent, CalWORKs Timed-Out, Child-Only Case. This program provides for continued cash and Denti-Cal coverage of children whose parents have been discontinued from cash aid and removed from the AU due to reaching the CalWORKs 60-month time limit without meeting a time extender extension.

For additional information please call Denti-Cal toll-free at (800) 423-0507.

California Medi-Cal Dental Program

Denti-Cal Bulletin

VOLUME 19, NUMBER 23 P.O. BOX 15609 SACRAMENTO, CALIFORNIA 95852-0609 AUGUST 2003

CHANGES IN COVERED BENEFITS AS SET FORTH IN SENATE BILL 26 (SBX1 26)

Effective July 1, 2003, the Department of Health Services implemented changes in covered benefits as set forth in Senate Bill 26 (SBX1 26), amending Welfare and Institutions Code Section 14132.88. Changes were made to the criteria for posterior laboratory processed crowns, to the definition of prefabricated crowns, and to the reimbursement rate for procedure 452. ***Effective August 1, 2003, these same changes also apply to the Child Treatment Program (CTP).***

The County Medical Services Program (CMSP) is not subject to change at the present time.

RESTRICTION OF POSTERIOR LABORATORY PROCESSED CROWNS

Posterior laboratory processed crowns (procedure 650, 651, 652, 653, 660 and 663) are no longer a benefit for adults 21 years of age and older except when the posterior tooth is used as an abutment for a fixed partial denture that meets current program criteria, or for a removable partial denture with cast clasps and rests. The crown must also meet existing criteria for medical necessity. For existing removable partial dentures, providers must submit a radiograph or photograph that demonstrates that the removable partial denture has a cast clasp or rest that is supported by the requested crown. When an abutment crown is requested as part of a treatment plan that is to include a new removable partial denture, providers must submit the crown and the removable partial denture on the same Treatment Authorization Request (TAR). The requested removable partial denture in this scenario must meet existing program criteria. The restriction on posterior laboratory processed crowns includes both premolars and molars.

Notices of Authorization were processed and mailed to providers up to and including June 30, 2003, however all crowns must have been cemented prior to July 1, 2003 in order to be considered for payment. There will be no consideration for payment, full or partial, for undelivered crowns. ***If cemented July 1, 2003 or any date of service thereafter, payment cannot be made and will be disallowed using the following adjudication reason code:***

263 Procedure requested is not a benefit for adults.

Denti-Cal created a new adjudication reason code to assist in processing the TARs received after July 1, 2003:

113C Laboratory processed crowns are not a benefit for posterior teeth except for abutments for any fixed or removable prosthesis with cast clasps and rests. Please reevaluate for alternate treatment.

Denti-Cal modified the following adjudication reason codes to assist in processing TARs received after July 1, 2003:

113 Tooth does not meet manual of criteria requirements for laboratory processed crowns. Please reevaluate for alternate treatment.

113B Per x-rays, documentation or clinical evaluation, tooth is developmentally immature. Please reevaluate for alternate treatment.

PREFABRICATED CROWNS MADE FROM ADA-APPROVED MATERIALS

Beginning July 1, 2003, all services rendered for any prefabricated crown made of ADA-approved or certified materials used as a final restoration on posterior teeth will be reimbursed as a stainless steel crown (procedures 670 or 671). This will remain in effect until CDT codes are implemented for Denti-Cal. Prefabricated crowns will remain a benefit for posterior teeth.

RATE REDUCTION FOR SUBGINGIVAL CURETTAGE AND ROOT PLANING

Effective for dates of service beginning July 1, 2003, the reimbursement rate for subgingival curettage and root planing (procedure 452) has been decreased from $200 to $118 for all beneficiaries with the exception of those residing in a Skilled Nursing Facility (SNF) or an Intermediate Care Facility (ICF) for the Developmentally Disabled. This rate change also affects those services with a TAR approved prior to July 1, 2003 at the higher rate. The rate for beneficiaries residing in a SNF or ICF will not change.

For beneficiaries residing in a SNF or ICF, place of service fields 4, 5, or 8 must be indicated on the document in box 22, as explained in Section 3 of the Denti-Cal Provider Manual, in order to ensure payment at the correct rate. Place of service 4 or 5 should be indicated when treatment is performed in the SNF or ICF facility. Those providers treating a SNF or ICF beneficiary outside the facility in which they reside, either in a mobile van, at the provider's office, or in a hospital, must indicate place of service 8 in box 22, as explained in Section 3 of the Denti-Cal Provider Manual. Providers must supply the beneficiary's SNF or ICF facility name, address and telephone number in box 34 (Comments). If any other place of service is indicated, or those fields are left blank, the reduced rate will be paid. Please note: beneficiaries who reside in a SNF or ICF will continue to be screened for medical necessity.

If you have additional questions, please call Denti-Cal toll-free at (800) 423-0507.

California Medi-Cal Dental Program

Denti-Cal Bulletin

VOLUME 19, NUMBER 24 P.O. BOX 15609 SACRAMENTO, CALIFORNIA 95852-0609 AUGUST 2003

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA) TRANSACTIONS AND CODE SETS: DENTI-CAL ELECTRONIC DATA INTERCHANGE (EDI) PROVIDERS

Denti-Cal is making every effort to comply with HIPAA regulations, however, some of the HIPAA transactions and the code sets project will not meet the October 16, 2003 implementation deadline. ***Providers must continue to follow existing billing instructions until otherwise notified through future bulletin updates.*** This information is supplemental to the HIPAA updates provided in your March bulletin. It is very important to review your monthly bulletins for more detailed instructions and implementation schedules related to HIPAA compliance.

As with paper claims, until further notice Denti-Cal will only be accepting local codes. Denti-Cal is aware that this may cause difficulties for the compliance of EDI billing providers and/or their vendors or clearinghouses. Denti-Cal has advised them of this requirement.

The Workgroup for Electronic Data Interchange (WEDI) submitted a letter to the Secretary of the Department of Health and Human Services (DHHS) dated April 15, 2003. In this letter, WEDI made the following requests for consideration:

- "Permitting compliant covered entities to utilize HIPAA TCS [Transaction Code Sets] standard transactions that may not contain all required data content elements, if these transactions can otherwise be processed to completion by the receiving entity, until such time as compliance is achieved or penalties are assessed."
- "Permitting compliant covered entities to establish a brief transition period to continue utilizing their current electronic transactions in lieu of reversion to paper transactions."

For further information or to read the letter in its entirety, please refer to WEDI's website referenced below.

Denti-Cal anticipates changes for both electronic and paper billing submission requirements during the period of HIPAA implementation. These changes, as well as DHHS' response to WEDI's request, will continue to be communicated through regular provider bulletins.

For additional information regarding HIPAA, please refer to the following websites:

- www.medi-cal.ca.gov - Medi-Cal website
- www.dhs.cahwnet.gov/hipaa/ - Department of Health Services Office of HIPAA Compliance
- aspe.hhs.gov/admnsimp/ - Department of Health and Human Services
- http://www.wedi.org/cmsUploads/pdfUpload/commentLetters/pub/Letter_to_Sec_Thompson_pdf.pdf - Workgroup for Electronic Data Interchange

Direct emails to: DentiCal_HIPAA@delta.org. All emails will be responded to as quickly as possible.

California Medi-Cal Dental Program

Denti-Cal Bulletin

VOLUME 19, NUMBER 25 P.O. BOX 15609 SACRAMENTO, CALIFORNIA 95852-0609 AUGUST 2003

PROGRAM ENROLLMENT

This bulletin contains the application requirements for participation in the California Medi-Cal Dental Program. The following forms and documents must be completed and approved prior to enrollment in the Medi-Cal Dental Program and prior to treating Medi-Cal beneficiaries.

To prevent enrollment processing delays, please follow these guidelines:

Medi-Cal Dental Provider Number Request (DC-005)

The Medi-Cal Dental Provider Number Request (DC-005) form and the Medi-Cal Provider Disclosure Statement of Significant Beneficial Interests (DC-013) form are required to request any of the following actions:

- Individual dental provider with sole ownership, requesting to apply for a Medi-Cal Dental billing provider number;
- Individual dental provider with a current Medi-Cal Dental billing provider number, requesting to add an additional place of practice, utilizing a different Tax Identification Number (TIN);
- A current Medi-Cal Dental billing provider with sole ownership, requesting to add an additional place of practice as a new corporation and/or new partnership;
- A current Medi-Cal Dental billing provider, individual practice, requesting to add rendering provider(s) to become a group practice;
- Schools, clinics and universities requesting to enroll a new practice;
- Hygienists, non-profit organizations, mobile practices, and out-of-state providers opening a new practice, applying for a Medi-Cal Dental billing provider number;
- Two or more dentists working in the same location, requesting to enroll as a group provider;
- Currently enrolled group or individual practice, changing the enrollment status, for example:
  - Dissolution of partnership;
  - A change from sole proprietor to partnership;
  - A change from group to single practice.

It is the responsibility of each Medi-Cal Dental Program billing provider to enroll all rendering providers in each service office prior to treating Medi-Cal beneficiaries. If an un-enrolled rendering provider performs services on a Medi-Cal beneficiary, payment for those services billed will be denied.

The following documents must be submitted along with the completed Medi-Cal Dental Provider Number Request (DC-005) form package:

- Valid legible copy of the current Dental License(s) issued by the Dental Board of California (DBC) (mandatory);
- Valid legible copy of the current driver's license or state-issued identification card for all rendering provider(s) (mandatory);

- Medi-Cal Provider Disclosure Statement of Significant Beneficial Interests (DC-013) form for each rendering provider. (Include copies of driver's license or state-issued identification card of providers/business owners with five percent or more controlling interest in the dental practice) (mandatory). If additional forms are needed, a photocopy is acceptable, **however original signatures are required (blue ink preferred);**
- Valid legible copy of each billing and rendering provider(s) Narcotics License Certification issued by the Drug Enforcement Agency (DEA) (if applicable);
- Valid legible copy of each billing and rendering provider(s) Anesthesia Permit issued by the appropriate licensing agency (if applicable);
- Valid legible copy of all appropriate certifications for each billing and rendering provider(s) for the Dental Specialty (if applicable);
- Federal Employer Identification Number (EIN) or Tax Identification Number (TIN) (Form 941, 147-C, SS-4 (Confirmation Notification), 2363, or 8109C) (if applicable);
- Form W-9 (only required if filing taxes with a Social Security Number (SSN);
- Copy of the current lease agreement (if applicable);
- Valid legible copy of the Fictitious Name Permit (if applicable);
- Valid legible copy of the Articles of Incorporation (if applicable);
- Valid legible copy of the Partnership Agreement (if applicable);
- Valid legible copy of the Business License issued by the city or county (if applicable);
- Valid legible copy of the Management Agreement (if applicable).

Additional Service Office Information (DC-011)

Medi-Cal Dental providers are required to notify the Medi-Cal Dental Program of any additional service office locations. To add an additional service office location to a Medi-Cal Dental billing provider number, licensed dentists/hygienists who have ownership or controlling interest in any office other than the primary location must obtain an Additional Service Office Permit issued by the Dental Board of California. An Additional Service Office Permit must be included along with the completed Additional Service Office Information (DC-011) form.

The Additional Service Office Information (DC-011) form and the Medi-Cal Provider Disclosure Statement of Significant Beneficial Interests (DC-013) form are required when requesting any of the following actions:

- Sole proprietor, adding additional service office location(s) with no change to the existing type of practice or business;
- Group provider, adding additional service office location(s) with no change to the existing type of practice or business.

The Additional Service Office Information (DC-011) form, and the following documents must be returned:

- Valid legible copy of the Additional Service Office Permit (issued by the Dental Board of California);
- Valid legible copy of each billing and rendering provider's Dental License(s) issued by the Dental Board of California (DBC) (mandatory);
- Valid legible copy of Driver's license or state-issued identification card for each rendering provider(s) (mandatory);
- Medi-Cal Provider Disclosure Statement of Significant Beneficial Interests (DC-013) form for each billing and rendering provider. (Include copies of driver's license or state-issued identification card of providers/business owners with five percent or more controlling interest

in the dental practice (mandatory)). If additional forms are needed, a photocopy is acceptable, **however, original signatures are required (blue ink preferred);**

- Valid legible copy of each billing and rendering provider(s) Anesthesia Permit issued by the appropriate licensing agency (if applicable);
- Valid legible copy of all dental specialty certifications for each billing and rendering provider(s) (if applicable);
- Federal Employer Identification Number (EIN) or Tax Identification Number (TIN) (Form 941, 147-C, SS-4 (Confirmation Notification), 2363, or 8109C) (if applicable);
- Form W-9 (only required if filing taxes with a Social Security Number (SSN);
- Copy of the current lease agreement (if applicable);
- Valid legible copy of the Fictitious Name Permit (if applicable);
- Valid legible copy of the Articles of Incorporation (if applicable);
- Valid legible copy of the Partnership Agreement (if applicable);
- Valid legible copy of the Business License issued by the city or county (if applicable);
- Valid legible copy of the Management Agreement (if applicable).

Do not complete the DC-011 if you are making a business entity change that involves proprietorship, partnership, corporation or a change to the type of practice. A Medi-Cal Dental Provider Number Request (DC-005) form must be completed for these types of actions.

Medi-Cal Dental Provider Information Change/Deletion Request (DC-012)

The Medi-Cal Dental Provider Information Change/Deletion Request (DC-012) form is required when making the following changes to an existing Medi-Cal Dental billing provider number:

- Change pay-to office address;
- Change service office address and/or telephone number. These changes require the following documents:
  - Valid copy of current lease agreement for the new service office location;
  - Valid legible copy of the Business License issued by the city or county (if applicable);
  - Medi-Cal Provider Disclosure Statement of Significant Beneficial Interests (DC-013) form for each billing and rendering provider. (Include copies of driver's license or state-issued identification card of providers/business owners with five percent or more controlling interest in the dental practice (mandatory)). If additional forms are needed, a photocopy is acceptable, **however, original signatures are required (blue ink preferred);**
- When adding a rendering provider to more than one service office location, a completed Medi-Cal Dental Provider Information Change/Deletion Request (DC-012) form and a Medi-Cal Provider Disclosure Statement of Significant Beneficial Interests (DC-013) form are required for each rendering provider being added to each service office location;
- Group practice(s) deleting a rendering provider from a service office;
- Group practice(s) adding a rendering provider to a service office;
- When adding a rendering provider the following documents are required:
  - Valid legible copy of each rendering provider(s) Dental License(s) issued by the Dental Board of California (DBC) (mandatory);
  - Valid legible copy of each rendering provider(s) driver's license or state-issued identification card (mandatory);
  - Valid legible copy of each rendering provider(s) Narcotics License issued by the Drug Enforcement Agency (DEA) (if applicable);

    - Valid legible copy of each rendering provider(s) Anesthesia Permit issued by the appropriate licensing agency (if applicable);
    - Valid legible copy of all dental specialty certifications for each rendering provider(s) (if applicable);
    - Medi-Cal Provider Disclosure Statement of Significant Beneficial Interests (DC-013) form for each rendering provider. (Include copies of driver's license or state-issued identification card of providers/business owners with five percent or more controlling interest in the dental practice (mandatory)). If additional forms are needed, a photocopy is acceptable, **however, original signatures are required (blue ink preferred);**
    - Valid legible copy of the Management Agreement (if applicable);
- When changing the Tax Identification Number (TIN) or Employer Identification Number (EIN), submit a valid legible copy of the official Internal Revenue Service (IRS) Form 941, Form 8109-C, Form 147-C, Form SS-4 (Confirmation Notification), or Form 2363 document to verify your name and TIN (business name must match name on the document(s);
- When changing a Business Name (if incorporated, submit a valid legible copy of the Articles of Incorporation verifying the name of the corporation. If said corporation is also doing business under a fictitious name, a copy of the Fictitious Name Permit issued by the Dental Board of California must also be attached) (name must match name on the document(s)).

Do not complete the DC-012 if you are making a business entity change that involves proprietorship, partnership, corporation or a change to the type of practice. A Medi-Cal Dental Provider Number Request (DC-005) form must be completed for these types of actions.

The application(s) will be returned as incomplete for any of the following reasons:

- Photocopies of signatures and/or signature stamps;
- Required documents, missing or incomplete;
- Correction fluid and/or correction tape.

Corrections to the enrollment applications and any other forms or documents may be made by lining through the incorrect information, entering the correct information, and initialing and dating the correction. **Signatures must be original, blue ink preferred, and not altered with correction fluid or correction tape.**

Continued Enrollment in the Medi-Cal Dental Program

In order to remain actively enrolled in the Medi-Cal Dental Program, providers must comply with all enrollment requirements.

Medi-Cal Dental Program providers will automatically be inactivated from the Medi-Cal Dental Program if any of the following occurs:

- Dental license is expired, revoked, inactivated, denied renewal, or suspended by the Dental Board of California;
- Twelve months with no claim activity in the Medi-Cal Dental Program;
- Mail is returned by the post office marked "Undeliverable" due to incorrect address.

Upon inactivation, providers will be required to re-apply in the Medi-Cal Dental Program.

To ensure you receive the most current enrollment application and information, please request an application by calling Provider Services at (800) 423-0507.

California Medi-Cal Dental Program

Denti-Cal Bulletin

VOLUME 19, NUMBER 26 P.O. BOX 15609 SACRAMENTO, CALIFORNIA 95852-0609 AUGUST 2003

REMINDER: CLAIMS COMPLETION AND DOCUMENTATION REQUIREMENTS FOR EMERGENCY DENTAL SERVICES

Some Medi-Cal beneficiaries are assigned aid codes that limit their dental benefits to emergency procedures. An emergency dental condition is a dental condition manifesting itself by acute symptoms of sufficient severity, including severe pain, which in the absence of immediate dental attention could reasonably be expected to result in any of the following: placing the patient's health in serious jeopardy, serious impairment to bodily functions or serious dysfunction of any bodily organ or part. The emergency must be certified by the dental provider in accordance with Section 51056 of Title 22, California Code of Regulations. The Department of Health Services may review the provider's decision that an emergency existed and that the services were medically necessary.

When billing for emergency services, providers must indicate emergency treatment by submitting an emergency certification statement. The statement must be either entered in the "Comments" area (box 34) on the claim form or attached to the claim. The emergency certification statement must describe the nature of the emergency, including clinical information pertinent to the patient's condition, and must explain why the emergency services provided were considered immediately necessary. The statement must be signed by the provider (in the "Comments" box or an attached statement) and must be comprehensive enough to support the existence of an emergency dental condition; merely stating that an emergency existed or that the patient was in pain is not sufficient. For example, decay that does not approach the pulp is not considered an emergency, nor does the placement of multiple restorations constitute emergency treatment. In the case of a restoration that is purported to be an emergency service, each tooth number must be indicated, along with documentation that pain as well as near-pulpal exposure and/or fracture were present. Radiographic evidence of each tooth showing near-pulpal exposure or tooth fracture must be retained by the provider for in-office audit review. Investigators from the Attorney General's office and other regulatory agencies are reviewing cases where such conditions and treatment are routinely reported by the providers as emergencies.

HELPFUL HINTS TO ENSURE SPEEDY PROCESSING OF CLAIMS AND TREATMENT AUTHORIZATION REQUESTS (TARs)

Before submitting either a claim form for payment or a TAR for processing, verify that *all* necessary information is included. Submission of incomplete forms may require that Denti-Cal send a Resubmission Turnaround Document (RTD), resulting in processing and payment delay.

Submit correct procedure code for payment

- ✓ Current Dental Terminology (CDT) codes are not currently accepted by Denti-Cal and are considered invalid until such time as Department of Health Services adopts this coding standard.

- ✓ Effective August 1, 2003, any claim service line (CSL) submitted with an invalid procedure code or a blank procedure code field will be denied, whether submitted electronically or as paper documents.

The following list of RTD codes are areas where information is most frequently missing.

Submit rendering provider number (RTD Code 16)
Payment will not occur without the treating/rendering provider's Medi-Cal provider number listed in box 33 on the claim form.

Indicate date of service (RTD Code 46)
The Denti-Cal program requires that approved services be performed within a stipulated time frame. To qualify for payment of services rendered, box 29 of both the Notice of Authorization and claim form must be completed for each line item listed.

Indicate tooth surface (RTD Code 48)
Treatment will not be authorized nor payment made for treatment if box 27 on the claim and the TAR forms is blank.

Indicate upper/lower arch (RTD Code 49)
Treatment will not be authorized nor payment made for treatment if box 26 on the claim and the TAR forms is blank.

Submit type of partial, i.e., procedure number (RTD Code 50)
Use box 34 (comments) to record this information.

Procedure requires tooth code (RTD Code 51)
Treatment will not be authorized nor payment made for treatment if box 26 on the claim and the TAR forms is blank.

Submit missing fee(s) (RTD Code 59)
Treatment will not be authorized nor payment for treatment made if box 32 on the claim and the TAR forms is blank.

List teeth to be replaced & clasped (RTD Code 68)
This code is accompanied by RTD Code 67 (Incomplete DC054 form was submitted)
TARs requesting procedures for partial denture or stayplate must be accompanied by the DC054 (Justification of Need for Prosthesis) form, with the area "For Partial Denture or Stayplate" listing the teeth involved.

If you have additional questions, please call Denti-Cal toll-free at (800) 423-0507.

California Medi-Cal Dental Program

Denti-Cal Bulletin

VOLUME 19, NUMBER 27 P.O. BOX 15609 SACRAMENTO, CALIFORNIA 95852-0609 AUGUST 2003

SEMINAR SCHEDULE FOR FOURTH QUARTER, 2003

Basic Seminars

- Introduction to California Medi-Cal Dental Program
- Enrollment and Eligibility
- Proper Billing Procedures

Advanced Seminars

- Criteria Presented *by* a Dentist *for* Dentists and Staff
- View Actual Treatment Slides

Workshops

- Enrollment and Eligibility
- Criteria and Current Changes
- Hands-On Forms Completion
- HIPAA Informational Updates

Ortho Seminar

- Designed for Denti-Cal providers who limit their practices to orthodontics only
- Comprehensive information on certification, enrollment, billing procedures and criteria

ABOUT THE SEMINARS AND WORKSHOPS

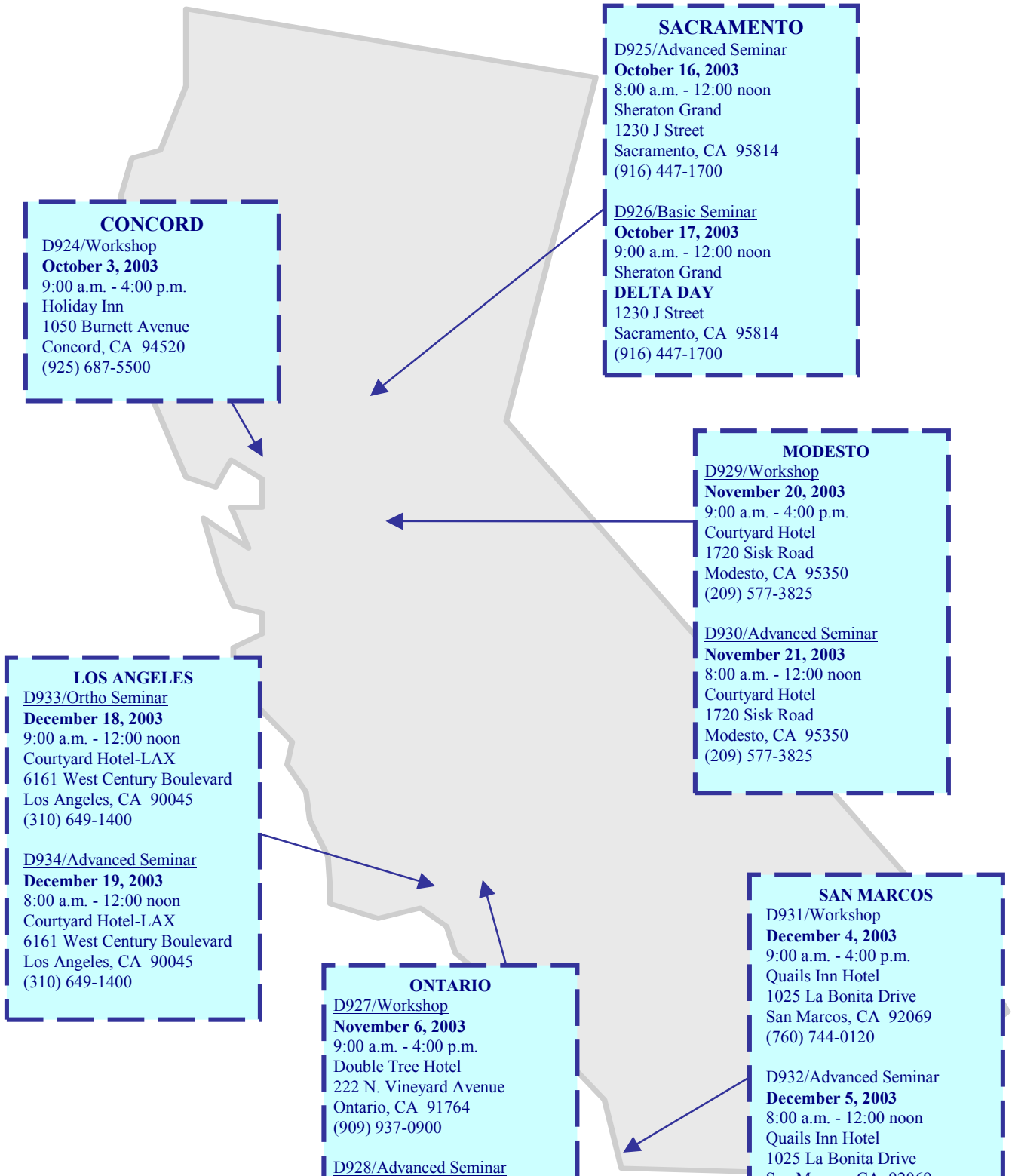
- ✓ Seminars and workshops are offered *free of charge*.
- ✓ Sessions begin *on time*, so arrive early.
- ✓ Bring your updated *Denti-Cal Provider Manual* to get the most from the training.
- ✓ Audio/video recording is not allowed.
- ✓ Billing information is subject to change.
- ✓ Reservations ensure that a space is available for you! Likewise, please let us know if you are unable to attend.
- ✓ Continuing education credits are available:

Basic Seminars	3 CE credits
Advanced Seminars	4 CE credits
Workshops	6 CE credits
Ortho Seminars	3 CE credits

- ✓ Some facilities may charge for parking.
- ✓ The use of cell phones during the seminar is strongly discouraged. If you must be available for calls, please be courteous and set the ringer on vibrate.

For additional information, questions and to register, please phone Denti-Cal toll free at 800/423-0507.

Denti-Cal Seminar Schedule
Fourth Quarter 2003



SACRAMENTO
D925/Advanced Seminar
October 16, 2003
8:00 a.m. - 12:00 noon
Sheraton Grand
1230 J Street
Sacramento, CA 95814
(916) 447-1700

D926/Basic Seminar
October 17, 2003
9:00 a.m. - 12:00 noon
Sheraton Grand
DELTA DAY
1230 J Street
Sacramento, CA 95814
(916) 447-1700

CONCORD
D924/Workshop
October 3, 2003
9:00 a.m. - 4:00 p.m.
Holiday Inn
1050 Burnett Avenue
Concord, CA 94520
(925) 687-5500

MODESTO
D929/Workshop
November 20, 2003
9:00 a.m. - 4:00 p.m.
Courtyard Hotel
1720 Sisk Road
Modesto, CA 95350
(209) 577-3825

D930/Advanced Seminar
November 21, 2003
8:00 a.m. - 12:00 noon
Courtyard Hotel
1720 Sisk Road
Modesto, CA 95350
(209) 577-3825

LOS ANGELES
D933/Ortho Seminar
December 18, 2003
9:00 a.m. - 12:00 noon
Courtyard Hotel-LAX
6161 West Century Boulevard
Los Angeles, CA 90045
(310) 649-1400

D934/Advanced Seminar
December 19, 2003
8:00 a.m. - 12:00 noon
Courtyard Hotel-LAX
6161 West Century Boulevard
Los Angeles, CA 90045
(310) 649-1400

ONTARIO
D927/Workshop
November 6, 2003
9:00 a.m. - 4:00 p.m.
Double Tree Hotel
222 N. Vineyard Avenue
Ontario, CA 91764
(909) 937-0900

D928/Advanced Seminar
November 7, 2003
8:00 a.m. - 12:00 noon
Double Tree Hotel
222 N. Vineyard Avenue
Ontario, CA 91764
(909) 937-0900

SAN MARCOS
D931/Workshop
December 4, 2003
9:00 a.m. - 4:00 p.m.
Quails Inn Hotel
1025 La Bonita Drive
San Marcos, CA 92069
(760) 744-0120

D932/Advanced Seminar
December 5, 2003
8:00 a.m. - 12:00 noon
Quails Inn Hotel
1025 La Bonita Drive
San Marcos, CA 92069
(760) 744-0120

DENTI-CAL PROVIDER TRAINING SEMINAR RESERVATION FORM

TYPE OF SEMINAR:

☐ Workshop
(Seminar Code Number:_____)

☐ Basic Seminar
(Seminar Code Number:_____)

☐ Advanced Seminar
(Seminar Code Number:_____)

☐ Ortho Seminar
(Seminar Code Number:_____)

Seating for all seminars is limited, so reserve your place today by returning this reservation form in the enclosed envelope to Denti-Cal. Be sure to include the seminar code number and indicate the names of staff who will be attending. Denti-Cal is unable to confirm your reservation by mail, so be sure to note the date and time on your calendar. ***To help us keep administrative costs down and continue to offer you free educational seminars, we request that you notify us in the event you need to cancel your reservation.***

PLEASE TYPE OR PRINT CLEARLY

Yes, I/my office staff wish to attend the Denti-Cal provider training seminar(s) indicated above. The name(s) of the person(s) attending are:

1._____ 4._____

2._____ 5._____

3._____ 6._____

In the area below, please type or print the dentist's name and office address:

_____ Provider No.:_____

_____

_____ Phone No.:_____

_____

California Medi-Cal Dental Program

Denti-Cal Bulletin

VOLUME 19, NUMBER 28 P.O. BOX 15609 SACRAMENTO, CALIFORNIA 95852-0609 AUGUST 2003

Learn About Electronic Claims Submission!

ELECTRONIC DATA INTERCHANGE SEMINARS
Fourth Quarter Schedule

Electronic Data Interchange (EDI) seminars provide a general introduction to electronic claims submission and helpful tips for offices currently submitting claims electronically. These *FREE* presentations cover the advantages of EDI, how electronic claims are processed, how to best utilize electronic reports and other practical hints.

Fourth Quarter 2003 Seminar Schedule

DATE	CITY	TIME	LOCATION/PHONE NUMBER
October 17	Sacramento	1:00 p.m. to 4:00 p.m.	Sheraton Grand 1230 J Street (916) 447-1700
November 7	Santa Barbara	1:00 p.m. to 4:00 p.m.	Radisson Hotel 1111 E. Cabrillo Blvd. (805) 963-0744
December 5	Los Angeles	9:00 a.m. to noon	Four Points by Sheraton LAX 9750 Airport Blvd. (310) 645-4600

Seating is limited.
For reservations, please call Denti-Cal toll-free at (800) 423-0507.

Continuing education credits from the Academy of General Dentistry are available.

California Medi-Cal Dental Program

Denti-Cal Bulletin

VOLUME 19, NUMBER 29 P.O. BOX 15609 SACRAMENTO, CALIFORNIA 95852-0609 AUGUST 2003

REQUIRE DOCUMENTATION WITH CLAIMS FOR RESTORATIVE PROCEDURES PER AB 1762

Assembly Bill 1762, which was chaptered (became law) on August 11, 2003, has necessitated this revised bulletin that replaces the previous bulletin (July 2003, Volume 19, Number 21).

AB 1762 amends Welfare and Institutions (W&I) Code 14132.88(f) to require pretreatment radiograph documentation for post treatment claims to establish the medical necessity for dental restorations (fillings and prefabricated crowns) and to reduce fraudulent claims for unnecessary restorative services. In order to avoid any undue barriers to accessing dental care, pretreatment radiographic documentation for post treatment claims will be required only when there are four or more dental fillings being completed in any 12-month period, per beneficiary, and all claims for prefabricated crowns. Denti-Cal will review a subset of these claims using a computerized selection method.

For dates of services beginning October 1, 2003, the Department of Health Services will require the following:

- ✓ Pretreatment radiographic documentation for post treatment claims to establish the medical necessity for all ADA-approved prefabricated crowns (including stainless steel crowns).
  - For procedure 670 (primary teeth), the radiograph must clearly demonstrate decay, fracture, or other damage involving three or more tooth surfaces; or two surfaces extending extensively buccolingually or mesiodistally; or submitted in conjunction with pulpal therapy on the same tooth.
  - For procedure 671 (permanent teeth), the radiograph must clearly demonstrate traumatic or pathological destruction to the crown that is identical to the existing tooth type-specific criteria for laboratory-processed crowns; or that the stainless steel crown will restore an endondontically treated tooth.
- ✓ Medi-Cal Dental claims for restorative procedures (600, 601, 602, 603, 611, 612, 613, 614, 645, and 646) require submission of radiographs that clearly demonstrate that destruction to the tooth (decay, fracture, missing restorations, et cetera) extends through the dentinoenamel junction (DEJ). This submission requirement also applies to the replacement of existing restorations. The placing of restorations solely to replace tooth structure that was lost by attrition, abrasion or erosion, or solely for cosmetic purposes will continue to not be a benefit.

If dental radiographs are contraindicated for a particular patient, or if the submitted radiographs do not accurately depict the decay/destruction observed clinically, then providers should submit

intraoral photographs. The contraindication must be specifically documented. Intraoral photographs may be submitted with:

- ✓ Fiber Optic Transillumination
- ✓ DIAGNOdent Readings
- ✓ Caries Detection Dye
- ✓ Caries Risk Assessment
- ✓ Operating Room (O.R.) Report

Without photographic documentation augmented, if necessary, with the aforementioned clinical adjuncts used to diagnose caries, restorative services will be denied or modified when the submitted radiograph does not adequately show that the destruction penetrates the DEJ. The written statement "caries penetrates the DEJ" will no longer be considered adequate documentation for payment of a restoration. In addition, claims will be denied when necessary radiographs and/or photographs are not submitted. Should the claim be denied and/or exceptional circumstances exist, a Claim Inquiry Form (CIF) may be submitted for reconsideration.

Submitted radiographs and photographs must conform to the existing requirements and must be:

- ✓ Properly dated with the mm/dd/yy and labeled legibly with the patient's name as well as the Provider's name and Medi-Cal provider number. In order to enhance Denti-Cal's ability to return misplaced radiographs, it is recommended that providers also place the beneficiary's Social Security number or Benefits Identification Card number on the radiographs.
- ✓ Current: taken within the last 8 months for primary teeth and within the last 14 months for permanent teeth.
- ✓ Of diagnostic quality.
- ✓ Labeled "right" or "left."
- ✓ Radiographs in multiples of four or more must be mounted.

It is important that Denti-Cal Dental Consultants be able to correctly identify the area/arch/quadrant/tooth number(s) depicted in submitted intraoral photographs. If radiographs and/or photographs are NOT to be returned, indicate "do not return" on the envelope.

Providers who are currently using the Electronic Data Interchange (EDI) are encouraged to continue to use the EDI for procedure codes impacted by this bulletin. The documentation requirements as stated above apply to electronic claims, but radiographs, photographs and other clinical documentation DO NOT need to be mailed to Denti-Cal at the time the electronic claim is transmitted. Denti-Cal will select certain electronic claims using a computerized selection method and then request that the radiographs, photographs or attachments to support those claims be mailed. Electronic claims that are not selected will continue through the adjudication process. Providers who want to be considered for EDI should contact the Denti-Cal EDI Support Group at (916) 853-7373.

In the near future, a provider will be able to elect to submit a Treatment Authorization Request with restorative services listed, and include radiographs, photographs and other documentation. A bulletin will be forthcoming regarding this process.

California Schools of Dentistry participating in the University Pilot Project will continue to perform claims adjudication for their students in accordance with these program criteria.

For additional information please phone Denti-Cal toll-free at (800) 423-0507.

California Medi-Cal Dental Program

Denti-Cal Bulletin

VOLUME 19, NUMBER 30 P.O. BOX 15609 SACRAMENTO, CALIFORNIA 95852-0609 SEPTEMBER, 2003

NO CLAIM ACTIVITY FOR 12 MONTHS

The Welfare and Institutions Code states providers who have had no claim activity (submitting no claims or requesting reimbursement) in a twelve month period shall be deactivated. Welfare and Institutions Code Section 14043.62 reads as follows:

> The department shall deactivate, immediately and without prior notice, the provider numbers used by a provider to obtain reimbursement from the Medi-Cal program when warrants or documents mailed to a provider's mailing address or its pay to address, if any, or its service or business address, are returned by the United States Postal Service as not deliverable or when a provider has not submitted a claim for reimbursement from the Medi-Cal program for one year. Prior to taking this action the department shall use due diligence in attempting to contact the provider at its last known telephone number and ascertain if the return by the United States Postal Service is by mistake or shall use due diligence in attempting to contact the provider by telephone or in writing to ascertain whether the provider wishes to continue to participate in the Medi-Cal program. If deactivation pursuant to this section occurs, the provider shall meet the requirements for reapplication as specified in this article or the regulations adopted thereunder.

If you are deactivated and wish to re-enroll, please phone (800) 423-0507 to request an enrollment package. To remain in the Medi-Cal Program, please fill out the form below, stating why you wish to be an active provider. Send the form to: Denti-Cal, California Medi-Cal Dental Program, Post Office Box 15609, Sacramento, CA 95852-0609.

If you have any questions, please call Denti-Cal toll free at (800) 423-0507.

Yes, I wish to remain a provider in the California Medi-Cal Dental Program because _____

_____

Check the boxes that apply to your practice:

- ☐ AAH (Alameda Alliance Health)
- ☐ CCS (California Children's Services)
- ☐ DMC (Dental Managed Care) Plan Name: _____
- ☐ FQHC/RHC (Federally Qualified Health Clinic/Rural Health Clinic)
- ☐ GHPP (Genetically Handicapped Persons Program)
- ☐ GMC (Geographic Managed Care) Plan Name: _____
- ☐ HFP (Healthy Families Program)

_____ _____

Provider Name/Number Provider Signature

California Medi-Cal Dental Program

Denti-Cal Bulletin

VOLUME 19, NUMBER 31 P.O. BOX 15609 SACRAMENTO, CALIFORNIA 95852-0609 OCTOBER 2003

CHANGES IN COVERED BENEFITS AS SET FORTH IN SENATE BILL 26 (SBX1 26)

Effective July 1, 2003, the Department of Health Services implemented changes in covered benefits as set forth in Senate Bill 26 (SBX1 26), amending Welfare and Institutions Code Section 14132.88. Changes were made to the criteria for posterior laboratory processed crowns, to the definition of prefabricated crowns, and to the reimbursement rate for procedure 452. Effective August 1, 2003, these same changes also apply to the Child Treatment Program (CTP).

This is to confirm information in check stuffers received during the month of August. Effective September 1, 2003, these same changes also apply to the County Medical Services Program (CMSP).

RESTRICTION OF POSTERIOR LABORATORY PROCESSED CROWNS

Effective July 1, 2003, posterior laboratory processed crowns (procedure 650, 651, 652, 653, 660 and 663) are no longer a benefit for adults 21 years of age and older except when the posterior tooth is used as an abutment for a fixed partial denture that meets current program criteria, or for a removable partial denture with cast clasps and rests. The crown must also meet existing criteria for medical necessity. For existing removable partial dentures, providers must submit a radiograph or photograph that demonstrates that the removable partial denture has a cast clasp or rest that is supported by the requested crown. When an abutment crown is requested as part of a treatment plan that is to include a new removable partial denture, providers must submit the crown and the removable partial denture on the same Treatment Authorization Request (TAR). The requested removable partial denture in this scenario must meet existing program criteria. The restriction on posterior laboratory processed crowns includes both premolars and molars. Effective August 1, 2003, these same changes also apply to the Child Treatment Program (CTP).

This is to confirm information in check stuffers received during the month of August. Effective September 1, 2003, these same changes also apply to the County Medical Services Program (CMSP).

PREFABRICATED CROWNS MADE FROM ADA-APPROVED MATERIALS

Beginning July 1, 2003, all services rendered for any prefabricated crown made of ADA-approved or certified materials used as a final restoration on posterior teeth will be reimbursed as a stainless steel crown (procedures 670 or 671). This will remain in effect until CDT codes

are implemented for Denti-Cal. Prefabricated crowns will remain a benefit for posterior teeth. Effective August 1, 2003, these same changes also apply to the Child Treatment Program (CTP).

This is to confirm information in check stuffers received during the month of August. Effective September 1, 2003, these same changes also apply to the County Medical Services Program (CMSP).

RATE REDUCTION FOR SUBGINGIVAL CURETTAGE AND ROOT PLANING

Effective for dates of service beginning July 1, 2003, the reimbursement rate for subgingival curettage and root planing (procedure 452) has been decreased from $200 to $118 for all beneficiaries with the exception of those residing in a Skilled Nursing Facility (SNF) or an Intermediate Care Facility (ICF) for the Developmentally Disabled. This rate change also affects those services with a TAR approved prior to July 1, 2003 at the higher rate. The rate for beneficiaries residing in a SNF or ICF will not change.

For beneficiaries residing in a SNF or ICF, place of service fields 4, 5, or 8 must be indicated on the document in box 22, as explained in Section 3 of the Denti-Cal Provider Manual, in order to ensure payment at the correct rate. Place of service 4 or 5 should be indicated when treatment is performed in the SNF or ICF facility. Those providers treating a SNF or ICF beneficiary outside the facility in which they reside, either in a mobile van, at the provider's office, or in a hospital, must indicate place of service 8 in box 22, as explained in Section 3 of the Denti-Cal Provider Manual. Providers must supply the beneficiary's SNF or ICF facility name, address and telephone number in box 34 (Comments). If any other place of service is indicated, or those fields are left blank, the reduced rate will be paid. Please note: beneficiaries who reside in a SNF or ICF will continue to be screened for medical necessity. Effective August 1, 2003, these same changes also apply to the Child Treatment Program (CTP).

This is to confirm information in check stuffers received during the month of August. Effective September 1, 2003, these same changes also apply to the County Medical Services Program (CMSP).

For additional information please phone Denti-Cal toll-free at (800) 423-0507.

California Medi-Cal Dental Program

Denti-Cal Bulletin

VOLUME 19, NUMBER 32 P.O. BOX 15609 SACRAMENTO, CALIFORNIA 95852-0609 OCTOBER 2003

NEW AID CODE 0V FOR EMERGENCY, LONG TERM CARE (LTC), AND PREGNANCY RELATED SERVICES

The Breast and Cervical Cancer Treatment Program (BCCTP) aid code 0U provides services for females with unsatisfactory immigrant status, who are under 65 years of age, and who have been diagnosed with breast and/or cervical cancer and found in need of treatment. This aid code has a maximum enrollment period of 18 months for breast cancer and 24 months for cervical cancer. Once these individuals reach the end of the allotted time period, they are no longer eligible to receive cancer-related services under the 0U aid code, even if cancer treatment is still necessary.

Although no longer eligible for BCCTP services aid code 0U, they will be eligible for limited scope services under the new aid code 0V. Aid Code 0V is valid for individuals who need emergency, LTC, or pregnancy services. These individuals must be under 65 years of age and do not have any other creditable health insurance.

Effective July 1, 2003, the Department of Health Services is implementing Aid Code 0V.

0V Provides Emergency, Long Term Care, and Pregnancy-related services, with no share of cost, to individuals no longer eligible for the Breast and Cervical Cancer Treatment Program.

NEW AID CODES 4P AND 4R - CALWORKS FAMILY REUNIFICATION

California Work Opportunity and Responsibility to Kids (CalWORKs) services include welfare-to-work activities, including mental health and substance abuse treatment or any other activities allowable under CalWORKs, including supportive services.

Any biological or adoptive parent whose eligible child(ren) has/have been removed from the home and placed in out-of-home care is eligible to continue to receive a CalWORKs grant and services for up to a full calendar month of what is anticipated to be a temporary absence.

New aid codes 4P and 4R are <u>not eligible for dental services</u>.

4P CalWORKs FAMILY REUNIFICATION-ALL FAMILIES, provides for the continuance of CalWORKs services to all families except two parent families, under certain circumstances, when a child has been removed from the home and is receiving out-of-home care.

4R CalWORKs FAMILY REUNIFICATION-TWO PARENT, provides for the continuation of CalWORKs services to two-parent families, under certain circumstances, when a child has been removed from the home and is receiving out-of-home care.

NEW ADJUDICATION REASON CODE 261B

As of August 1, 2003, any Claim Service Line (CSL) submitted with an invalid procedure code (not contained in the Schedule of Maximum Allowances (SMA)) or a blank procedure code field is being denied, whether submitted electronically or as paper documents. The following adjudication reason code will assist in the processing of these documents:

261A Procedure code is missing or is not a valid Denti-Cal code.

Additionally, Current Dental Terminology (CDT) codes are not accepted by Denti-Cal and are considered invalid until such time as Department of Health Services adopts this coding standard. Denti-Cal has created a new adjudication reason code to assist in processing these documents.

261B CDT codes are not being accepted at this time.

If you have additional questions, please call Denti-Cal toll-free at (800) 423-0507 or by email at DentiCal_HIPAA@delta.org.

REMINDER: DENTAL CRITERIA FOR BALANCE OF A COMPLETE DENTURE

The following defines balance and the criteria established for removable partial dentures under the Denti-Cal program:

> Balance: A removable partial denture is covered only when necessary for the balance of a complete opposing denture. Balance is considered to be the presence of sufficient occluding posterior teeth to afford satisfactory biomechanical support of a *full* prosthetic appliance in all excursions of the mandible. A removable partial denture shall be considered necessary for the balance of a complete denture when, in the arch opposite the edentulous area, at least (excluding the third molars unless the third molar is occupying the position of the second molar and is in functional occlusion):
>
> 1. Four (4) adjacent natural posterior teeth are missing on the same side.
> 2. Three (3) adjacent natural posterior teeth are missing on the same side if the first bicuspid remains on the same side.
> 3. All four (4) natural permanent molars are missing.
> 4. Five (5) posterior permanent teeth are missing.

For additional information on dental criteria for balance of a complete denture, please refer to Section 6 – Glossary, of the *Denti-Cal Provider Manual*.

For additional information please phone Denti-Cal toll-free at (800) 423-0507.

California Medi-Cal Dental Program

Denti-Cal Bulletin

VOLUME 19, NUMBER 33 P.O. BOX 15609 SACRAMENTO, CALIFORNIA 95852-0609 NOVEMBER 2003

FIVE PERCENT (5%) REDUCTION IN SCHEDULE OF MAXIMUM ALLOWANCES (SMA)

Effective for dates of service on or after January 1, 2004, Medi-Cal is reducing payments for all services by five percent (5%) in accordance with the directives contained in AB 1762, Chapter 230 (Statutes of 2003). Further, in accordance with this statute, rate reductions shall remain in effect until January 1, 2007, at which time Medi-Cal anticipates a return to the current SMA.

This reduction also applies to Child Treatment Program (CTP) and County Medical Service Programs (CMSP).

Notices of Authorization (NOAs) received for payment on or after January 1, 2004 with dates of service December 31, 2003 and before, will be paid at the present rate. NOAs with dates of service on or after January 1, 2004 will be paid at the reduced rate. *Providers are reminded to always use their Usual and Customary Fees when submitting for payment.*

Look for an updated SMA in the quarterly release of the Denti-Cal Provider Manual.

For answers to additional questions, please call Denti-Cal toll-free at (800) 423-0507.

California Medi-Cal Dental Program

Denti-Cal Bulletin

VOLUME 19, NUMBER 34 P.O. BOX 15609 SACRAMENTO, CALIFORNIA 95852-0609 NOVEMBER 2003

Learn About Electronic Claims Submission!

ELECTRONIC DATA INTERCHANGE SEMINARS
First Quarter Schedule

Electronic Data Interchange (EDI) seminars provide a general introduction to electronic claims submission and helpful tips for offices currently submitting claims electronically. These *FREE* presentations cover the advantages of EDI, how electronic claims are processed, how to best utilize electronic reports and other practical hints.

First Quarter 2004 Seminar Schedules

DATE	CITY	TIME	LOCATION/PHONE NUMBER
January 16	Concord	9:00 a.m. to noon	Sheraton Concord Hotel 45 John Glenn Drive 925-825-7700
February 13	San Diego	9:00 a.m. to noon	Town & Country Hotel 500 Hotel Circle North 619-291-7131
March 12	Bakersfield	9:00 a.m. to noon	Doubletree Hotel 3100 Camino Del Rio Court 661-323-7111

Seating is limited.
For reservations, please call Denti-Cal toll-free at (800) 423-0507.

Continuing education credits from the Academy of General Dentistry are available.

California Medi-Cal Dental Program

Denti-Cal Bulletin

VOLUME 19, NUMBER 35 P.O. BOX 15609 SACRAMENTO, CALIFORNIA 95852-0609 NOVEMBER 2003

SEMINAR SCHEDULE FOR FIRST QUARTER, 2004

Basic Seminars

- Introduction to California Medi-Cal Dental Program
- Enrollment and Eligibility
- Proper Billing Procedures

Advanced Seminars

- Criteria Presented *by* a Dentist *for* Dentists and Staff
- View Actual Treatment Slides

Workshops

- Enrollment and Eligibility
- Criteria and Current Changes
- Hands-On Forms Completion
- HIPAA Informational Updates

ABOUT THE SEMINARS AND WORKSHOPS

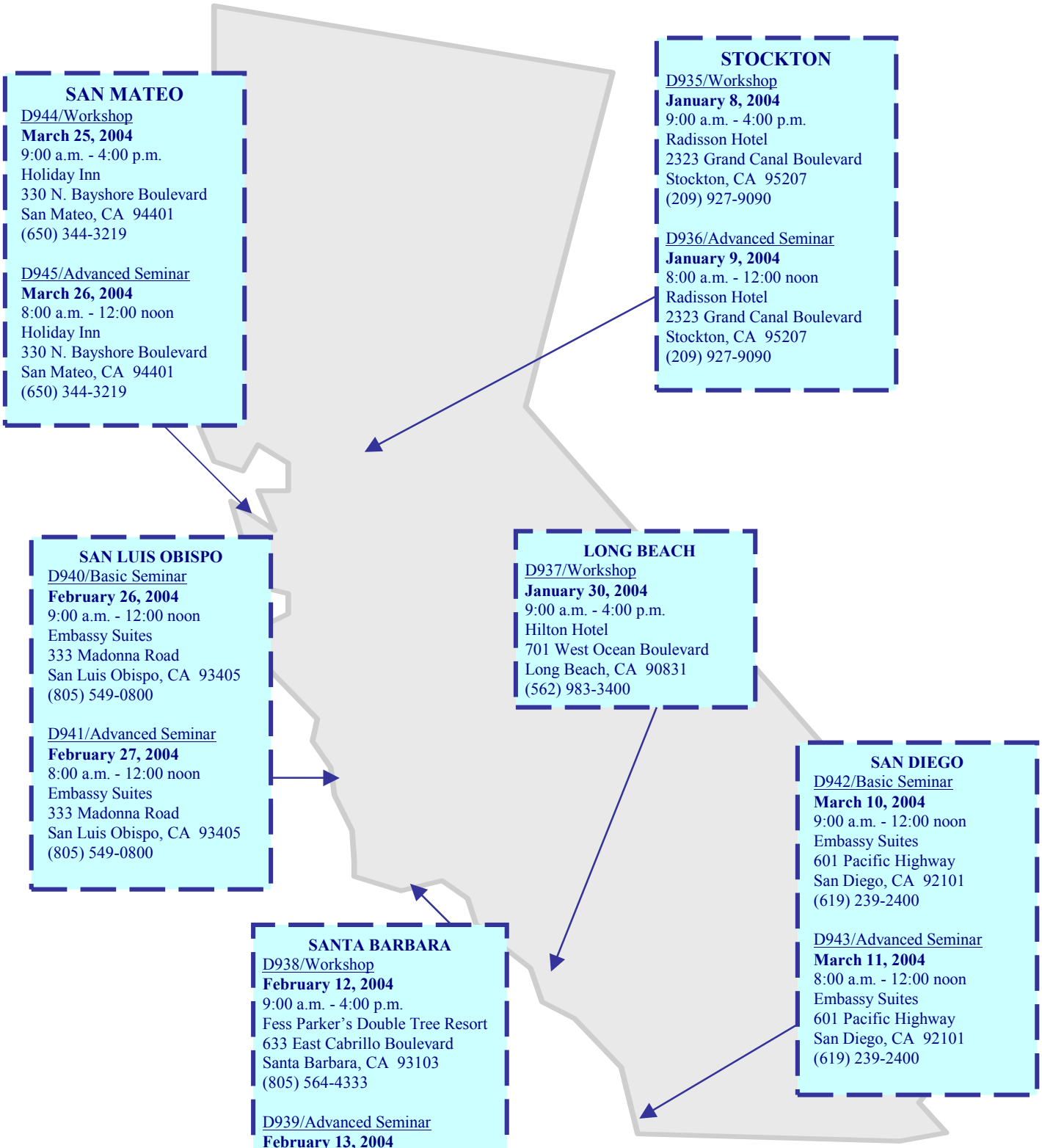
- ✓ Seminars and workshops are offered *free of charge*.
- ✓ Sessions begin *on time*, so arrive early.
- ✓ Bring your updated *Denti-Cal Provider Manual* to get the most from the training.
- ✓ Audio/video recording is not allowed.
- ✓ Billing information is subject to change.
- ✓ Reservations ensure that a space is available for you! Likewise, please let us know if you are unable to attend.
- ✓ Continuing education credits are available:

Basic Seminars	3 CE credits
Advanced Seminars	4 CE credits
Workshops	6 CE credits

- ✓ Some facilities may charge for parking.
- ✓ The use of cell phones during the seminar is strongly discouraged. If you must be available for calls, please be courteous and set the ringer on vibrate.

For additional information, questions and to register, please phone Denti-Cal toll free at 800/423-0507.

Denti-Cal Seminar Schedule
First Quarter 2004



SAN MATEO
D944/Workshop
March 25, 2004
9:00 a.m. - 4:00 p.m.
Holiday Inn
330 N. Bayshore Boulevard
San Mateo, CA 94401
(650) 344-3219

D945/Advanced Seminar
March 26, 2004
8:00 a.m. - 12:00 noon
Holiday Inn
330 N. Bayshore Boulevard
San Mateo, CA 94401
(650) 344-3219

STOCKTON
D935/Workshop
January 8, 2004
9:00 a.m. - 4:00 p.m.
Radisson Hotel
2323 Grand Canal Boulevard
Stockton, CA 95207
(209) 927-9090

D936/Advanced Seminar
January 9, 2004
8:00 a.m. - 12:00 noon
Radisson Hotel
2323 Grand Canal Boulevard
Stockton, CA 95207
(209) 927-9090

SAN LUIS OBISPO
D940/Basic Seminar
February 26, 2004
9:00 a.m. - 12:00 noon
Embassy Suites
333 Madonna Road
San Luis Obispo, CA 93405
(805) 549-0800

D941/Advanced Seminar
February 27, 2004
8:00 a.m. - 12:00 noon
Embassy Suites
333 Madonna Road
San Luis Obispo, CA 93405
(805) 549-0800

LONG BEACH
D937/Workshop
January 30, 2004
9:00 a.m. - 4:00 p.m.
Hilton Hotel
701 West Ocean Boulevard
Long Beach, CA 90831
(562) 983-3400

SAN DIEGO
D942/Basic Seminar
March 10, 2004
9:00 a.m. - 12:00 noon
Embassy Suites
601 Pacific Highway
San Diego, CA 92101
(619) 239-2400

D943/Advanced Seminar
March 11, 2004
8:00 a.m. - 12:00 noon
Embassy Suites
601 Pacific Highway
San Diego, CA 92101
(619) 239-2400

SANTA BARBARA
D938/Workshop
February 12, 2004
9:00 a.m. - 4:00 p.m.
Fess Parker's Double Tree Resort
633 East Cabrillo Boulevard
Santa Barbara, CA 93103
(805) 564-4333

D939/Advanced Seminar
February 13, 2004
8:00 a.m. - 12:00 noon
Fess Parker's Double Tree Resort
633 East Cabrillo Boulevard
Santa Barbara, CA 93103
(805) 564-4333

DENTI-CAL PROVIDER TRAINING SEMINAR RESERVATION FORM

TYPE OF SEMINAR:

☐ Workshop
(Seminar Code Number:_____)

☐ Basic Seminar
(Seminar Code Number:_____)

☐ Advanced Seminar
(Seminar Code Number:_____)

Seating for all seminars is limited, so reserve your place today by returning this reservation form in the enclosed envelope to Denti-Cal. Be sure to include the seminar code number and indicate the names of staff who will be attending. Denti-Cal is unable to confirm your reservation by mail, so be sure to note the date and time on your calendar. ***To help us keep administrative costs down and continue to offer you free educational seminars, we request that you notify us in the event you need to cancel your reservation.***

PLEASE TYPE OR PRINT CLEARLY

Yes, I/my office staff wish to attend the Denti-Cal provider training seminar(s) indicated above. The name(s) of the person(s) attending are:

1._____ 4._____

2._____ 5._____

3._____ 6._____

In the area below, please type or print the dentist's name and office address:

_____ Provider No.:_____

_____

_____ Phone No.:_____

_____

California Medi-Cal Dental Program

Denti-Cal Bulletin

VOLUME 19, NUMBER 36 P.O. BOX 15609 SACRAMENTO, CALIFORNIA 95852-0609 DECEMBER 2003

FIVE PERCENT (5%) REDUCTION IN SCHEDULE OF MAXIMUM ALLOWANCES (SMA)

Effective for dates of service on or after January 1, 2004, Medi-Cal is reducing payments for all services by five percent (5%) in accordance with the directives contained in AB 1762, Chapter 230, Statutes of 2003. (See attached, revised SMA Schedule). Further, in accordance with this statute, rate reductions shall remain in effect until January 1, 2007, at which time Medi-Cal anticipates a return to the current SMA.

This reduction also applies to Child Treatment Program (CTP) and County Medical Service Programs (CMSP).

Notices of Authorization (NOAs) received for payment on or after January 1, 2004 with dates of service December 31, 2003 and before, will be paid at the present rate. NOAs with dates of service on or after January 1, 2004 will be paid at the reduced rate. *Providers are reminded to always use their usual and customary fees when submitting for payment.*

For answers to additional questions, please call Denti-Cal toll-free at (800) 423-0507.

DENTI-CAL SCHEDULE
OF MAXIMUM ALLOWANCES

Effective January 1, 2004

1. Fees payable to providers by Denti-Cal for covered services shall be LESSER of:
   a. the fee charged by the provider
   b. the charges for dental services shall be reimbursed in accordance with the Department of Health Services maximum reimbursement rates as follows
   c. the maximum allowance set forth in the schedule below
2. Procedures limited to children (under age 18) are indicated by an asterisk (*).
3. Refer to your Denti-Cal Handbook for specific procedure instructions and program limitations.

Procedure Number	Procedure	Maximum Allowance ($)
Visits – Diagnostic (000-199)		
010	Examination, initial episode of treatment only	23.75
015	Evaluation, periodic	14.25
020	Office visit during regular office hours for Treatment and observation of injuries to the teeth and supporting structures	19.00
030	Professional visit after regular office hours, or to bedside	33.25
035	Hospital Care	47.50
040	Specialist Consultation	33.25
045	Pit and Fissure Dental Sealants for Permanent First Molars, to age twenty-one (21)	20.90
046	Pit and Fissure Dental Sealants for Permanent Second Molars, to age twenty-one (21)	20.90
049*	Prophylaxis, beneficiaries through age 12	28.50
050	Prophylaxis, beneficiaries age 13 years and older	38.00
061*	Prophylaxis, including topical application of fluoride—Beneficiaries age 5 and under	33.25
062*	Prophylaxis, including topical application of fluoride –Beneficiaries age 6 through 17	38.00
080	Emergency Treatment, palliative	42.75
110	Intraoral periapical,, single, first film	9.50
111	Intraoral periapical, each additional film (maximum 10 films)	2.85
112	Intraoral, complete series consisting of at least 14 periapical films plus bitewings	42.75
113	Intraoral, occlusal, each film	9.50
114	Extraoral, single, head or lateral jaw	20.90
115	Extraoral, each additional, head or lateral jaw	4.75
116	Bitewings, two films	9.50
117	Bitewings, four films	17.10
118	Bitewing, anterior, one film	4.75
119	Photograph or slide, first	6.65
120	Photograph or slide, each additional (maximum 5)	2.85
125	Panographic-type film, single film	23.75
150	Biopsy of oral tissue	95.00
160	Gross and microscopic histopathological report	47.50

Procedure Number	Procedure	Maximum Allowance ($)
Oral Surgery (200-299)		
200	Removal of erupted tooth, uncomplicated, first tooth	42.75
201	Removal of erupted tooth, uncomplicated, each additional tooth	36.10
202	Removal of erupted tooth, surgical	80.75
203	Removal of root or root tip, completely covered by bone	95.00
204	Removal of root or root tip, not completely covered by bone	38.00
220	Postoperative visit, complications (e.g., osteitis)	14.25
230	Removal of impacted tooth – soft tissue	95.00
231	Removal of impacted tooth – partially bony	128.25
232	Removal of impacted tooth – completely bony	156.75
250	Alveoloplasty per quadrant, edentulous	95.00
252	Alveoloplasty per quadrant, in conjunction with extractions	47.50
255	Vestibuloplasty, submucosal resection (not to include grafts)	380.00
256	Alveoloplasty with ridge extension, secondary epithelialization (per arch)	190.00
257	Removal of palatal exostosis (torus)	190.00
258	Removal of mandibular exostosis (torus) per quadrant	95.00
259	Excision of hyperplastic tissue (per arch)	95.00
260	Incision and drainage of abscess, intraoral	47.50
261	Incision and drainage of abscess, extraoral	71.25
262	Excision pericoronal gingiva, operculectomy	47.50
263	Sialolithotomy intraoral	223.25
264	Sialolithotomy extraoral	285.00
265	Closure of salivary fistula	114.00
266	Dilation of salivary duct	114.00
267	Reduction of tuberosity, unilateral	71.25
269	Excision of benign tumor, up to 1.25 cm	95.00
270	Excision of benign tumor, larger than 1.25 cm	237.50
271	Excision of malignant tumor	308.75
273	Reimplantation and/or stabilization of accidentally evulsed or displaced permanent tooth and/or alveolus	166.25
275*	Transplantation of tooth or tooth bud	950.00

Procedure Number	Procedure	Maximum Allowance ($)
276	Removal of foreign body from bone (independent procedure)	123.50
277	Radical resection of bone for tumor with bone graft	1140.00
278	Maxillary sinusotomy for removal of tooth fraction or foreign body	361.00
279	Oral—antral fistula closure	285.00
280	Excision of cyst, up to 1.25 cm	95.00
281	Excision of cyst, over 1.25 cm	190.00
282	Sequestrectomy	95.00
285	Condylectomy of mandible, unilateral	950.00
289	Menisectomy of temporomandibular joint, unilateral	950.00
290	Excision of foreign body, soft tissue	57.00
291	Frenectomy, or frenotomy, separate procedure	95.00
292	Suture of soft tissue wound or injury	47.50
294	Injection of sclerosing agent into temporomandibular joint	71.25
295	Injection of trigeminal nerve branches for destruction	190.00
296	Surgical exposure of impacted or unerupted tooth to aid eruption, soft tissues	95.00
297	Surgical exposure of impacted or unerupted tooth to aid eruption, partially bony	128.25
298	Surgical exposure of impacted or unerupted tooth to aid eruption, completely bony or ectopic eruption	128.25
299	Unlisted surgical service or procedure	By Report
Drugs and Anesthesia (300-400)		
300	Injectable drugs	14.25
301	Conscious sedation relative analgesia (nitrous oxide) per visit	23.75
400	General anesthesia	95.00
Periodontics (450-499)		
451	Emergency treatment (periodontal abscess, Acute periodontitis, etc.)	52.25
452	Subgingival curettage and root planing per treatment	112.10
452	Subgingival curettage and root planing per treatment (residents of SNF or ICF)	190.00
453	Occlusal adjustment (limited) per quadrant (minor spot grinding	23.75
472	Gingivectomy or gingivoplasty per quadrant	157.70
473	Osseous and mucogingival surgery per quadrant	332.50
474	Gingivectomy, or gingivoplasty, treatment per tooth (fewer than six teeth)	47.50
Endodontics (500-599)		
501	Therapeutic pulpotomy	67.45
502	Vital pulpotomy	67.45
503	Recalcification, includes temporary restoration, per tooth	38.95
511	Anterior root canal therapy	204.25
512	Bicuspid root canal therapy	247.00
513	Molar root canal therapy	313.50
530	Apicoectomy—surgical procedure in conjunction with root canal therapy	285.00
b	Apicoectomy (separate surgical procedure), per tooth	95.00
534	Apexification/apexogenesis (therapeutic apical closure), per treatment	95.00
Restorative Dentistry (600-679)		
Amalgam Restorations		
600*	One surface, primary tooth	33.25
601*	Two surfaces, primary tooth	40.85
602*	Three surfaces, primary tooth	47.50
603*	Four or more surfaces, primary tooth (maximum)	54.15
611	One surface, permanent tooth	37.05
612	Two surfaces, permanent tooth	45.60
613	Three surfaces, permanent tooth	54.15
614	Four or more surfaces, permanent tooth (maximum)	57.00
Silicate, Composite, Plastic Restorations		
640	Silicate cement restoration	0.00
641	Silicate restorations, two or more in a single tooth (maximum)	0.00
645	Composite or plastic restoration	52.25
646	Composite or plastic restorations two or more in a single tooth (maximum)	80.75
648	Pin retention (per pin) maximum three pins per tooth	76.00
Crowns		
650	Crown, plastic (laboratory processed)	142.50
651	Crown, plastic with metal	209.00
652	Crown, porcelain	356.25
653	Crown, porcelain fused to metal	323.00
660	Crown, cast full	323.00
663	Crown, cast, three quarters	356.25
670*	Crown, stainless steel (primary)	71.25
671	Crown, stainless steel (permanent)	85.50
672	Cast metal dowel post	71.25
Prosthetics (680-799)		
Pontics		
680	Fixed bridge pontic, cast metal	308.75
681	Fixed bridge pontic, slotted facing	308.75
682	Fixed bridge pontic, slotted pontic	308.75
692	Fixed bridge pontic, porcelain fused to metal	308.75
693	Fixed bridge pontic, plastic processed to metal	308.75
Recementation		
685	Recement inlay, facing, pontic	28.50
686	Recement crown	28.50
687	Recement bridge	47.50
Repairs, Crown, and Bridge		
690	Repair fixed bridge	By Report
694	Replace broken tru-pontic	71.25
695	Replace broken facing, post intact	71.25
696	Replace broken facing, post backing broken	71.25
Removal Prosthodontics		
700	Complete maxillary denture	427.50
701	Complete mandibular denture	427.50

Procedure Number	Procedure	Maximum Allowance ($)
702	Partial upper or lower denture with two assembled chrome cobalt wrought or cast chrome cobalt clasps with occlusal rests and necessary teeth, acrylic base	394.25
703	Partial upper or lower denture with cast chrome cobalt skeleton, two cast clasps, and necessary teeth.	380.00
704	Clasps, third and each additional clasp for Procedure 703	38.00
705	Stress breakers, extra	38.00
706	Partial upper or lower stayplate, acrylic-base fee, teeth and clasps extra	142.50
708	Partial upper or lower denture, all acrylic with two assembled chrome cobalt wrought clasps having two clasp arms, but no rests, and necessary teeth	261.25
709	Clasp, third and each additional for Procedure 708	23.75
712	Clasp, third and each additional for Procedure 702	23.75
716	Clasp or teeth, each for Procedure 706	21.85
720	Denture adjustment, per visit	23.75
721	Reline—office, cold cure	66.50
722	Reline—laboratory processed	133.00
723	Tissue conditioning, per denture	47.50
724	Denture duplication ("jump," "reconstruction") denture base including necessary tooth replacement, per denture	142.50
	Repairs, Dentures, Acrylic	
750	Repair broken denture base only (complete or partial)	42.75
751	Repair broken denture and replace one broken denture tooth	61.75
752	Each additional denture tooth replaced on 751 repair (maximum two)	14.25
753	Replace one broken denture tooth only (complete or partial)	47.50
754	Each additional denture tooth replaced on 753 repair (maximum two)	14.25
755	Adding first tooth to partial denture to replace newly extracted natural tooth	61.75
756	Each additional natural tooth replaced on 755 repair (maximum two)	28.50
757	Add a new or replace a broken chrome cobalt assembled wrought clasp with two clasp arms and no rest to an existing 702 partial denture	71.25
758	Each additional new or replacement clasp for repair 757 (maximum two)	71.25
759	Add a new or replace a broken chrome cobalt assembled wrought clasp with two clasp arms and no rest to an existing 708 partial denture	71.25
760	Each additional new or replacement clasp for repair 759 (maximum two)	47.50
761	Reattaching clasp on partial denture, clasp intact, each (maximum two)	57.00
762	Add a new or replace a broken cast chrome Cobalt clasp with two clasp arms and rest to an existing 703 partial denture	71.25
763	Each additional new or replacement clasp for repair 762 (maximum two)	71.25
	Space Maintainers (800-899)	
800	Fixed, unilateral band type (including band)	114.00
801	Removable, plastic, with two stainless steel round wire clasps or rests	218.50
802	Each additional clap or rest (for 801 only)	14.25
811	Fixed, unilateral stainless steel crown type (including crown, Procedure 670 or 671)	105.45
812	Fixed, bilateral, lingual or palatal bar type	190.00
832	Fixed or removable appliance to control harmful habit	209.95
	Fractures and Dislocations (900-949)	
	(includes usual follow-up care)	
900	Maxilla, open reduction, simple	950.00
901	Maxilla, closed reduction, simple	475.00
902	Mandible, open reduction, simple	1140.00
903	Mandible, closed reduction, simple	665.00
904	Maxilla, closed reduction, compound	760.000
905	Maxilla, open reduction, compound	1140.00
906	Mandible, closed reduction, compound	760.00
907	Mandible, open reduction, compound	1140.00
913	Reduction of dislocation of Temporomandibular joint	133.00
915	Treatment of malar fracture, simple; closed Reduction	237.50
916	Treatment of malar fracture, simple or Compound depressed, open reduction	475.00
	Unlisted Procedures	
999	Fees to be determined by Report	

DENTI-CAL SCHEDULE
OF MAXILLOFACIAL DENTAL SERVICES

Effective January 1, 2004

1. Fees payable to providers by Denti-Cal for covered services shall be the LESSER of:
   a. the fee charged by the provider
   b. maximum allowances or
   c. the maximum allowance set forth in the schedule below

Procedure Number	Procedure	Maximum Allowance ($)
Diagnostic Services (950-957)		
950	Clinical examination and consultation, including study models	95.00
952	Prosthetic evaluation and treatment plan, including study models	95.00
955	TMJ series radiographs	95.00
956	Cephalometric head film, single, first film, including tracing	47.50
957	Cephalometric head film, each additional film, including tracing	9.50
Maxillofacial Prosthetic Services (960-982)		
960	Speech appliance, transitional, with or without pharyngeal extension	760.00
962	Speech appliance, permanent, edentulous, with or without pharyngealextension	1330.00
964	Speech appliance, permanent, partially edentulous, cast framework, with or without pharyngeal extension	1425.00
966	Palatal lift, interim	760.00
968	Palatal lift permanent, cast framework	1330.00
970	Obturator, immediate surgical routine	855.00
971	Obturator, immediate surgical complex	1140.00
972	Obturator, permanent, complex	1425.00
973	Resection prosthesis, permanent, edentulous, complex	1425.00
974	Resection prosthesis, permanent, edentulous, routine	1330.00
975	Resection prosthesis, permanent, partially edentulous, complex	1615.00
976	Repositioner, mandibular, two piece	2185.00
977	Removable facial prosthesis	By Report
978	Splints and stents	By Report
979	Radiation therapy fluoride carrier	76.00
980	Repairs, maxillofacial prosthesis	By Report
981	Rebase laboratory processed, maxillofacial prosthesis	By Report
982	Balancing (opposing) maxillofacial prosthesis	By Report
Maxillofacial Surgical Procedures		
985	Maxillofacial surgical procedures	By Report
Temporomandibular Joint Dysfunction Management (990-998)		
990	Occlusal analysis, including report and/or models	171.00
992	Occlusal adjustments, limited centric and excursive adjustments,including records and/or models	85.50
994	Occlusal balancing, altering centric relation, including records and/or models	380.00
995	Orthopedic stabilizing appliance, disocclusion splint	285.00
996	Postoperative visits, symptomatic care and counseling	71.25
998	Unlisted therapeutic service	By Report

DENTI-CAL SCHEDULE OF CLEFT PALATE ORTHODONTIC SERVICES

Effective January 1, 2004

1. Reimbursement for orthodontic dental services in the treatment of handicapping malocclusion and cleft palate deformities shall be the usual charge to the general public, not to exceed the maximum reimbursement rate listed.
2. Maximum allowances.

Procedure Number	Procedure	Maximum Allowance ($)
Malocclusion Cases (551-558)		
551	Initial Orthodontic Examination/Handicapping Labio-Lingual Deviation Index	33.25
552	Banding and materials	617.50
554	Per treatment visit24 months maximum. One visit maximum per calendar month	66.50
556	Quarterly observation 6 quarters maximum	47.50
557	Diagnostic work-up and photographs (additional dental services are listed separately in Section 51506(b), procedure 112Intraoral, complete series; and Section 51506.1(b), procedure codes 956 and 957 cephalometric head films, including tracing)	95.00
558	Study models	71.25
Cleft Palate Cases (560-582)		
Primary Dentition		
560	Diagnostic work-up, photographs and study models (complete mouth series radiographs, procedure code 112, and cephalometric head films, procedure codes 956 and 957 including tracing, are separately payable at State fee schedule)	190.00
562	Banding and materials	285.00
564	Per treatment visit - 10 visits maximum, one visit per calendar month	47.50
Mixed Dentition		
570	Banding and materials	475.00
572	Per treatment visit - 14 visits maximum. One visit maximum per calendar month	47.50
Permanent Dentition		
580	Banding and materials	760.00
582	Per treatment visit - 30 visits maximum. One visit per calendar month	95.00

Procedure Number	Procedure	Maximum Allowance ($)
Facial Growth Management (590-598)		
590	Diagnostic work-up, photographs and study models (complete mouth series radiographs, procedure code 112, and cephalometric head films, procedure codes 956 and 957 including tracing, are separately payable at State fee schedule)	95.00
592	Quarterly observation, maximum 6 quarters	47.50
594	Progress records prior to treatment	95.00
596	Banding and materials	760.00
598	Per treatment visit24 visits maximum. One visit maximum per calendar month	95.00
Malocclusion, Cleft Palate and Facial Growth Management Cases – Retention (556-599)		
556	Quarterly observation 6 quarters maximum	47.50
599	Retainer, removable, for each upper and lower	190.00

CHDP/CTP FEE SCHEDULE

Effective January 1, 2004

Procedure Number	Procedure	CHDP/CTP Rate
Visits - Diagnostic (000-199)		
010	Examination, initial episode of treatment only	23.75
015	Examination, periodic	14.25
020	Office visit during regular office hours for treatment and observation of injuries to the teeth and supporting structures	19.00
030	Professional visit after regular office hours, or to bedside	33.25
035	Hospital Care	47.50
040	Specialist Consultation	33.25
045	Pit and Fissure Dental Sealants for Permanent First Molars, to age twenty-one (21)	20.90
046	Pit and Fissure Dental Sealants for Permanent Second Molars, to age twenty-one (21)	20.90
049*	Prophylaxis, beneficiaries through age 12	28.50
050	Prophylaxis, beneficiaries age 13 years and older	38.00
061*	Prophylaxis, including topical application of fluoride beneficiaries age 5 and under	33.25
062*	Prophylaxis, including topical application of fluoride beneficiaries age 6 through 17	38.00
080	Emergency Treatment, palliative	42.75
110	Intraoral periapical, single, first film	9.50
111	Intraoral periapical, each additional film (maximum 10 films)	2.85
112	Intraoral, complete series consisting of at least 14 periapical films plus bitewings	42.75
113	Intraoral, occlusal, each film	9.50
114	Extraoral, single, head or lateral jaw	20.90
115	Extraoral, each additional, head or lateral jaw	4.75
116	Bitewings, two films	9.50
117	Bitewings, four films	17.10
118	Bitewing, anterior, one film	4.75
119	Photograph or slide, first	6.65
120	Photograph or slide, each additional (maximum 5)	2.85
125	Panographic-type film, single film	23.75
150	Biopsy of oral tissue	95.00
160	Gross and microscopic histopathological report	47.50
Oral Surgery (200-299)		
200	Removal of erupted tooth, uncomplicated, first tooth	42.75
201	Removal of erupted tooth, uncomplicated, each additional tooth	36.10
202	Removal of erupted tooth, surgical	80.75
203	Removal of root or root tip, completely covered by bone	95.00
204	Removal of root or root tip, not completely covered by bone	38.00
220	Postoperative visit, complications (e.g. osteitis)	14.25
230	Removal of impacted tooth soft tissue	95.00
231	Removal of impacted tooth partially bony	128.25
232	Removal of impacted tooth completely bony	156.75
250	Alveoloplasty per quadrant, edentulous	95.00
252	Alveoloplasty per quadrant, in conjunction with extractions	47.50
255	Vestibuloplasty, submucosal resection (not to include grafts)	380.00
256	Alveoloplasty with ridge extension, secondary epithelialization (per arch)	190.00
257	Removal of palatal exostosis (torus)	190.00
258	Removal of mandibular exostosis (torus) per quadrant	95.00
259	Excision of hyperplastic tissue (per arch)	95.00
260	Incision and drainage of abscess, intraoral	47.50
261	Incision and drainage of abscess, extraoral	71.25
262	Excision pericoronal gingiva, operculectomy	47.50
263	Sialolithotomy intraoral	223.25
264	Sialolithotomy extraoral	285.00
265	Closure of salivary fistula	114.00
266	Dilation of salivary duct	114.00
267	Reduction of tuberosity, unilateral	71.25
269	Excision of benign tumor, up to 1.25 cm	95.00
270	Excision of benign tumor, larger than 1.25 cm	237.50
271	Excision of malignant tumor	308.75
273	Reimplantation and/or stabilization of accident-ally evulsed or displaced permanent tooth and/or alveolus	166.25
275*	Transplantation of tooth or tooth bud	950.00
276	Removal of foreign body from bone (inde-pendent procedure)	123.50
277	Radical resection of bone for tumor with bone graft	1140.00
278	Maxillary sinusotomy for removal of tooth fragment or foreign body	361.00
279	Oral antral fistula closure	285.00
280	Excision of cyst, up to 1.25 cm	95.00
281	Excision of cyst, over 1.25 cm	190.00

Procedure Number	Procedure	CHDP/CTP Rate
282	Sequestrectomy	95.00
285	Condylectomy of mandible, unilateral	950.00
289	Menisectomy of temporomandibular joint, unilateral	950.00
290	Excision of foreign body, soft tissue	57.00
291	Frenectomy, or frenotomy, separate procedure	95.00
292	Suture of soft tissue wound or injury	47.50
294	Injection of sclerosing agent into temporo-mandibular joint	71.25
295	Injection of trigeminal nerve branches for destruction	190.00
296	Surgical exposure of impacted or unerupted tooth to aid eruption, soft tissues	95.00
297	Surgical exposure of impacted or unerupted tooth to aid eruption, partially bony	128.25
298	Surgical exposure of impacted or unerupted tooth to aid eruption, completely bony or ectopic eruption	128.25
299	Unlisted surgical service or procedure	By Report

Drugs and Anesthesia (300-400)

300	Injectable drugs	14.25
301	Conscious sedation relative analgesia (nitrous oxide) per visit	23.75
400	General anesthesia	95.00

Periodontics (450-499)

451	Emergency treatment (periodontal abscess, acute periodontitis, etc.)	52.25
452	Subgingival curettage and root planing per treatment	112.10
452	Subgingival curettage and root planing per treatment (residents of SNF or ICF)	190.00
453	Occlusal adjustment (limited) per quadrant (minor) spot grinding)	23.75
472	Gingivectomy or gingivoplasty per quadrant	157.70
473	Osseous and mucogingival surgery per quadrant	332.50
474	Gingivectomy, or gingivoplasty, treatment per tooth (fewer than six teeth)	47.50

Endodontics (500-599)

501	Therapeutic pulpotomy	67.45
502	Vital pulpotomy	67.45
503	Recalcification, includes temporary restoration, per tooth	38.95
511	Anterior root canal therapy	204.25
512	Bicuspid root canal therapy	247.00
513	Molar root canal therapy	313.50
530	Apicoectomy surgical procedure in conjunction with root canal filling	285.00
531	Apicoectomy (separate surgical procedure), per tooth	95.00
534	Apexification/apexogenesis (therapeutic apical closure), per treatment	95.00

Restorative Dentistry (600-679)

Amalgam Restorations

600*	One surface, primary tooth	33.25
601*	Two surfaces, primary tooth	40.85
602*	Three surfaces, primary tooth	47.00
603*	Four or more surfaces, primary tooth (maximum)	54.15
611	One surface, permanent tooth	37.05
612	Two surfaces, permanent tooth	45.60
613	Three surfaces, permanent tooth	54.15
614	Four or more surfaces, permanent tooth (maximum)	57.00

Silicate, Composite, Plastic Restorations

640	Silicate cement restoration	0.00
641	Silicate restorations, two or more in a single tooth (maximum)	0.00
645	Composite or plastic restoration	52.25
646	Composite or plastic restorations two or more in a single tooth (maximum)	80.75
648	Pin retention (per pin) maximum three pins per tooth	76.00

Crowns

650	Crown, plastic (laboratory processed)	142.50
651	Crown, plastic with metal	209.00
652	Crown, porcelain	356.25
653	Crown, porcelain fused to metal	323.00
660	Crown, cast, full	323.00
663	Crown, cast, three quarters	356.25
670*	Crown, stainless steel (primary)	71.25
671	Crown, stainless steel (permanent)	85.50
672	Cast metal dowel post	71.25

Prosthetics (680-799)

Pontics

680	Fixed bridge pontic, cast metal	308.75
681	Fixed bridge pontic, slotted facing	308.75
682	Fixed bridge pontic, slotted pontic	308.75
692	Fixed bridge pontic, porcelain fused to metal	308.75
693	Fixed bridge pontic, plastic processed to metal	308.75

Recementation

685	Recement inlay, facing, pontic	28.50
686	Recement crown	28.50
687	Recement bridge	47.50

Procedure Number	Procedure	CHDP/CTP Rate
Repairs, Crown and Bridge		
690	Repair fixed bridge	By Report
694	Replace broken tru-pontic	71.25
695	Replace broken facing, post intact	71.25
696	Replace broken facing, post backing broken	71.25
Removable Prosthodontics		
700	Complete maxillary denture	427.50
701	Complete mandibular denture	427.50
702	Partial upper or lower denture with two assembled chrome cobalt wrought or cast chrome cobalt clasps with occlusal rests and necessary teeth, acrylic base	394.25
703	Partial upper or lower denture with cast chrome cobalt skeleton, two cast clasps, and necessary teeth	380.00
704	Clasps, third and each additional, clasp for Procedure 703	38.00
705	Stress breakers, extra	38.00
706	Partial upper or lower stayplate, acrylic base fee, teeth and clasps extra	142.50
708	Partial upper or lower denture, all acrylic with two assembled chrome cobalt wrought clasps having two clasp arms, but no rests, and necessary teeth	261.25
709	Clasp, third and each additional for Procedure 708	23.75
712	Clasp, third and each additional for Procedure 702	23.75
716	Clasp or teeth, each for Procedure 706	21.85
720	Denture adjustment, per visit	23.75
721	Reline office, cold cure	66.50
722	Reline laboratory processed	133.00
723	Tissue conditioning, per denture	47.50
724	Denture duplication ("jump," " reconstruction") denture base including necessary tooth replacement, per denture	142.50
Repairs, Dentures, Acrylic		
750	Repair broken denture base only (complete or partial)	42.75
751	Repair broken denture and replace one broken denture tooth	61.75
752	Each additional denture tooth replaced on 751 repair (maximum two)	14.25
753	Replace one broken denture tooth only (complete or partial)	47.50
754	Each additional denture tooth replaced on 753 repair (maximum two)	14.25
755	Adding first tooth to partial denture to replace newly extracted natural tooth	61.75
756	Each additional natural tooth replaced on 755 repair (maximum two)	28.50
757	Add a new or replace a broken chrome cobalt assembled wrought clasp with two clasp arms and no rest to an existing 702 partial denture	71.25
758	Each additional new or replacement clasp for repair 757 (maximum two)	71.25
759	Add a new or replace a broken chrome cobalt assembled wrought clasp with two clasp arms and no rest to an existing 708 partial denture	71.25
760	Each additional new or replacement clasp for repair 759 (maximum two)	47.50
761	Reattaching clasp on partial denture, clasp intact, each (maximum two)	57.00
762	Add a new or replace a broken cast chrome cobalt clasp with two clasp arms and rest to an existing 703 partial denture	71.25
763	Each additional new or replacement clasp for repair 762 (maximum two)	71.25
Space Maintainers (800-899)		
800	Fixed, unilateral band type (including band)	114.00
801	Removable, plastic, with two stainless steel round wire clasps or rests	218.50
802	Each additional clasp or rest (for 801 only)	14.25
811	Fixed, unilateral stainless steel crown type (including crown, Procedure 670 or 671)	105.45
812	Fixed, bilateral, lingual or palatal bar type	190.00
832	Fixed or removable appliance to control harmful habit	209.95
Fractures and Dislocations (900-949)		
	(includes usual follow-up care)	
900	Maxilla, open reduction, simple	950.00
901	Maxilla, closed reduction, simple	475.00
902	Mandible, open reduction, simple	1140.00
903	Mandible, closed reduction, simple	665.00
904	Maxilla, closed reduction, compound	760.00
905	Maxilla, open reduction, compound	1140.00
906	Mandible, closed reduction, compound	760.00
907	Mandible, open reduction, compound	1140.00
913	Reduction of dislocation of temporomandibular joint	133.00
915	Treatment of malar fracture, simple, closed reduction	237.50
916	Treatment of malar fracture, simple or compound depressed, open reduction	475.00
Maxillofacial Dental Services (950-998)		
Diagnostic Services		
950	Clinical examination and consultation, including study models	95.00
952	Prosthetic evaluation and treatment plan, including study models	95.00
955	TMJ series radiographs	95.00
956	Cephalometric head film, single, first film, including tracing	47.50
957	Cephalometric head film, each additional film, including tracing	9.50

Procedure Number	Procedure	CHDP/CTP Rate
Maxillofacial Prosthetic Services		
960	Speech appliance, transitional, with or without pharyngeal extension	760.00
962	Speech appliance, permanent, edentulous, with or without pharyngeal extension	1330.00
964	Speech appliance, permanent, partially edentulous, cast framework, with or without pharyngeal extension	1425.00
966	Palatal lift, interim	760.00
968	Palatal lift permanent, cast framework	1330.00
970	Obturator, immediate surgical routine	855.00
971	Obturator, immediate surgical complex	1140.00
972	Obturator, permanent, complex	1425.00
973	Resection prosthesis, permanent, edentulous, complex	1425.00
974	Resection prosthesis, permanent, edentulous, routine	1330.00
975	Resection prosthesis, permanent, partially edentulous, complex	1615.00
976	Repositioner, mandibular, two piece	2185.00
977	Removable facial prosthesis	By Report
978	Splints and stents	By Report
979	Radiation therapy fluoride carrier	80.00
980	Repairs, maxillofacial prosthesis	By Report
981	Rebase laboratory processed, maxillo-facial prosthesis	By Report
982	Balancing (opposing) maxillofacial prosthesis	By Report
Maxillofacial Surgical Procedures		
985	Maxillofacial surgical procedures	By Report
Temporomandibular Joint Dysfunction Management		
990	Occlusal analysis, including report and/or models	171.00
992	Occlusal adjustments, limited centric and excursive adjustments, including records and/or models	85.50
994	Occlusal balancing, altering centric relation, including records and/or models	380.00
995	Orthopedic stabilizing appliance, disocclusion splint	285.00
996	Postoperative visits, symptomatic care and counseling	71.75
998	Unlisted therapeutic service	By Report
Unlisted Procedures		
999		Fees to be determined by Report

Procedure Number	Procedure	CHDP/CTP Rate
Orthodontic Services		
Malocclusion Cases		
551	Initial Orthodontic Examination/Handicapping Labio-Lingual Deviation Index	33.25
552	Banding and materials	617.50
554	Per treatment visit – 24 months maximum One visit maximum per calendar month	66.50
556	Quarterly-observation-6 quarters maximum	47.50
557	Diagnostic work-up and photographs (additional dental services are listed separately in Section 51506(b), procedure 112-intraoral, complete series; and Section 51506.1(b), procedure codes 956 and 957-cephalometric head films	95.00
558	Study models	71.75
Cleft Palate Cases		
560	Diagnostic work-up, photographs and study models (complete mouth series radiographs, procedure code 112, and cephalometric head films, procedure codes 956 and 957 including tracing, are separately payable at State fee schedule)	190.00
562	Banding and materials	285.00
564	Per treatment visit – 10 visits maximum. One visit maximum per calendar month.	47.50
570	Banding and materials	475.00
572	Per treatment visit-14 visits maximum. One visit maximum per calendar month.	47.50
580	Banding and materials	760.00
582	Per treatment visit - 30 visits maximum. One visit per calendar month	95.00
Facial Growth Management		
590	Diagnostic work-up, photographs and study models (complete mouth series radiographs, procedure code 112, and cephalometric head films, procedure codes 956 and 957 including tracing, are separately payable at State fee schedule)	95.00
592	Quarterly observation, maximum 6 quarters	47.50
594	Progress records prior to treatment	950.00
596	Banding and materials	760.00
598	Per treatment visit24 visits maximum. One visit maximum per calendar month	95.00
Program Exception Procedure		
777	Program Exception Procedure	By Report

California Medi-Cal Dental Program

Denti-Cal Bulletin

VOLUME 19, NUMBER 37 P.O. BOX 15609 SACRAMENTO, CALIFORNIA 95852-0609 DECEMBER 2003

IMPACT OF SENATE BILL 857 (SB 857) AFFECTING THE MEDI-CAL DENTAL PROGRAM

Senate Bill 857 (SB 857), effective January 1, 2004, implements a process for the Department of Health Services (Department) to more thoroughly review providers applying for participation in the Medi-Cal Dental Program, including establishing a new provisional provider status. The provisions of SB 857 will also allow for more efficient identification of problematic and fraudulent provisional providers from the Medi-Cal Dental program.

Section 1. The heading of Article 1.3 (commencing with Section 14043) of Chapter 7 of Part 3 of Division 9 of the Welfare and Institutions Code.

For the Medi-Cal Dental Program, SB 857 key points are as follows:

Section 14043.26 - New providers will be enrolled as "provisional providers." These providers shall be subject to the terms of provisional provider status for a period of 12 months from the date of enrollment. After successful completion of the 12-month provisional period, the provider's status will be changed to reflect regular, active status.

All applicants must be processed within 180 days and, if approved, are given provisional provider status for 12 months. If the provider is not notified after 180 days, provisional provider status will be automatically invoked.

Section 14043.28 - Providers who are subsequently denied enrollment will not be eligible to reapply for a period of three (3) years.

Section 14123.25 - Providers will be notified of improper billing practices via deficiency notices. Subsequent notices to the same providers may result in civil penalties being imposed by the Department.

Section 14172.5 - Beginning January 1, 2004, the Department's collection procedures for established overpayments made to non-institutional providers will change. Prior to January 1, 2004, when a non-institutional provider filed a request for hearing, liquidation of the disputed overpayment was deferred until the appeal was finalized or rejected. Effective January 1, 2004, pursuant to SB 857, the Department shall pursue liquidation of the overpayment 60 days after issuance of the first statement of accountability or demand for repayment, regardless of the status of the provider's appeal.

To view the full text of the chaptered bill, enter the following website address for the State of California Official Legislative website and select either html or pdf:

http://www.leginfo.ca.gov/cgi-bin/postquery?bill_number=sb_857&sess=CUR&house=B&author=speier

California Medi-Cal Dental Program

Denti-Cal Bulletin

VOLUME 19, NUMBER 38 P.O. BOX 15609 SACRAMENTO, CALIFORNIA 95852-0609 DECEMBER 2003

APPROVED DENTAL RESTORATIVE MATERIALS AS SET FORTH IN ASSEMBLY BILL 999 (AB 999)

As a result of the recent enactment of AB 999 (Chapter 747, Statutes of 2003), effective January 1, 2004, providers may provide composite resin, glass ionomer cement, resin ionomer cement restorations in posterior teeth and bill Denti-Cal using amalgam restoration procedure codes. The proper procedure for submitting a claim is as follows:

- Use the appropriate amalgam restoration procedure code (procedures 600 through 614, inclusive) on the Claim Service Line, along with the tooth number/letter and surfaces restored.

- Describe the restorative material used in Box 34 (Comments). In accordance with Welfare & Institutions Code Section 14132.22(a), the accepted dental materials are limited to composite resin, glass ionomer cement, resin ionomer cement, and amalgam.

Reimbursement for the above claims will be at the fee for the appropriate amalgam restoration procedure code within the Schedule of Maximum allowances, or the billed amount, whichever is less. Providers are further instructed that they may not bill beneficiaries for the difference between the amount Denti-Cal pays on amalgam rates and their usual and customary fees for composites.

California Medi-Cal Dental Program

Denti-Cal Bulletin

VOLUME 19, NUMBER 39 P.O. BOX 15609 SACRAMENTO, CALIFORNIA 95852-0609 DECEMBER 2003

CHANGE IN PROCEDURE FOR RETURNING RADIOGRAPHS AND PHOTOGRAPHS

Effective January 1, 2004, radiographs and photographs will no longer be automatically returned to providers. Denti-Cal will recycle *all* radiographs and photographs received on or after January 1, 2004, *unless their return is specifically requested*. This change in procedure, suggested by a number of providers, is expected to help contain unnecessary program costs.

In accordance with ADA guidelines, only duplicate radiographs should be submitted to Denti-Cal and the originals should be retained in the patient's records. Double pack films offer the best solution for the beneficiary, the provider and the processing staff at Denti-Cal. High quality, diagnostic duplication of radiographs is also acceptable.

All radiographs or photographs accompanying documents must be submitted in the appropriate x-ray mailing envelopes. Radiographs or photographs submitted without return address or without x-ray envelopes will *not* be returned.

In the near future, "Return to Provider" stickers will be available for affixing to the x-ray mailing envelope. Until the stickers are available, it is imperative that preimprinted or typed return address x-ray mailing envelopes be used, with *"Return to Provider" clearly written on the envelope*.

California Medi-Cal Dental Program

Denti-Cal Bulletin

VOLUME 19, NUMBER 40 P.O. BOX 15609 SACRAMENTO, CALIFORNIA 95852-0609 DECEMBER 2003

REMINDER: VERIFY MESSAGES RECEIVED FROM AEVS CONCERNING ELIGIBILITY

Beneficiary eligibility information is immediately available on-line to Denti-Cal providers through the Medi-Cal Automated Eligibility Verification System (AEVS) by calling (800) 456-AEVS (2387) using a touch-tone phone. Providers whose practices are outside of California (border providers) should call (800) 866-2387. **Prior to treating the patient**, it is the responsibility of the provider to verify **current** eligibility even if there is an approved Notice of Authorization (NOA) for that patient. In addition, the provider should check for eligibility limitations such as: Share of Cost, Other Coverage, Healthy Families and/or Managed Care Plan enrollment. Failure to do so may result in non-payment or denial of claims.

Occasionally, eligibility information provided by AEVS may include a telephone number for that beneficiary's medical or dental plan. Provider offices requiring clarification of the eligibility message should call that number to request specific data concerning the beneficiary's coverage, or contact the Medi-Cal medical fiscal intermediary, EDS, at (800) 451-5555.

CLARIFICATION REGARDING PROGRAM TERMINOLOGY: "GLOBAL"

Under the Medi-Cal Dental program, global is defined as "treatment performed in conjunction with another procedure which is not payable separately."

Examples include, but are not limited to:

- Vitality tests, medicated treatments, final fillings of canals, and temporary and retrograde restorations included in the fee for all endodontic procedures.
- Restorative procedures (including crowns), tooth and soft tissue preparations (e.g., cord placement, gingivectomies and crown lengthening), amalgam or acrylic build-ups, temporary restorations, calcium hydroxide, cement and sedative bases, impressions, local anesthesia, occlusal adjustments, recementation of temporary crowns and the initial cementation of the permanent crown.
- Photographs are included in the fee for the orthodontic diagnostic work-up (procedure 557).
- Filling out forms, paperwork or reports, heart monitoring, waste disposal, behavior management, and hygiene instructions are considered global to other services rendered and are not payable separately.

REMINDER: HELPFUL HINTS FOR PREPARING NARRATIVE DOCUMENTATION

Denti-Cal's evaluation of Treatment Authorization Requests and claims will be more accurate when narrative documentation is included. The following reminders and tips help office staff

prepare narrative documentation for some common Denti-Cal procedures:

- The "Comments" area (box 34) of the treatment form is the best place to write narrative documentation. If including narrative documentation on a separate piece of paper, be sure to check box 10 on the treatment form to indicate there are other attachments. It is also helpful to note in area 34 that written comments are attached.
- Repeated use of "pattern" documentation for the same procedure is not acceptable. Narrative documentation should always state the facts that pertain to the specific situation.
- When submitting a request for a procedure that involves a partial denture, always include the type of partial denture (i.e., procedure 702, 703 or 708).
- Be sure to include the arch code (u = upper, l = lower) when requesting payment for denture repairs and adjustments. Documentation is required for repairs.
- Remember the following three things when documenting procedures 020 (office visit for observation), 080 (emergency palliative) and 451 (emergency periodontal):
  1. the patient's complaint;
  2. the diagnosis, including tooth number or area of involvement;
  3. the specific treatment provided.
- Documentation for procedure 720 (denture adjustment) *must* include the arch code and the location of the adjustment, e.g, "left buccal flange," "lingual of area #9," et cetera.
- If a surgical extraction was necessary to remove a tooth but the preoperative x-rays depict a simple extraction procedure, include narrative documentation to justify procedure 202.
- Submit all x-rays taken for root canal treatments and crown requests. Sometimes additional views are taken at different angles, which may be helpful in determining the necessity of the requested procedure.
- Evaluation of laboratory processed crowns (procedures 650-663) is enhanced by documentation that includes the extent of the decay and the specific cusps involved.
- Remember that narrative documentation should be legible; printed or typewritten documentation is always preferred. Be sure to change typewriter or computer printer ribbon frequently and try to avoid strikeovers, erasures or using correction fluid when printing or typing narrative documentation on the treatment form (Box 34).
- If submitting electronically, abbreviate comments to make optimum use of allotted space.

Refer to Section 4 of the *Denti-Cal Provider Manual* for additional documentation requirements. For answers to additional questions, please call Denti-Cal toll-free at (800) 423-0507.

REMINDER: *UPCOMING SEMINARS*

January 8, 2004	Workshop/D935	Stockton, CA
January 9, 2004	Advanced Seminar/D936	Stockton, CA
January 16, 2004	Electronic Data Interchange (EDI)	Concord, CA
January 30, 2004	Workshop/D937	Long Beach, CA

Check your seminar schedules (Denti-Cal Bulletins, Volume 19, Numbers 34 and 35) for specifics!

California Medi-Cal Dental Program

Denti-Cal Bulletin

VOLUME 19, NUMBER 41 P.O. BOX 15609 SACRAMENTO, CALIFORNIA 95852-0609 DECEMBER 2003

VERIFY YOUR TAX IDENTIFICATION NUMBER

Denti-Cal reports annually to the Internal Revenue Service (IRS) the amount paid to each enrolled billing provider. The payee's name and Tax Identification Number (TIN) must match **exactly** with the name and TIN on file with the IRS. The IRS requires Denti-Cal to withhold 31% of future payments if the name and TIN do not match exactly.

There are two types of TINs: social security numbers (SSN), and employer identification numbers (EIN). The TIN Denti-Cal uses to report payment to the IRS is printed on the front of the check and on the Explanation of Benefits (EOB) you receive from Denti-Cal. **Please verify that the name and TIN on the next check/EOB you receive from Denti-Cal is correct.** If the TIN and/or "doing business as" name is incorrect, please complete the form below, attach a valid, legible copy of Federal EIN or TIN (Form 941, 147-C, SS-4 (Confirmation Notification), 2363 or 8109C) and return to: Denti-Cal, Provider Enrollment, P.O. Box 15609, Sacramento, CA 95852-0609. *(Please keep a copy for your records.)* If you are doing business under a fictitious name, a valid, legible copy of your fictitious name permit issued by the **Dental Board of California** must be attached. You **do not** need to complete this form if the name and TIN that appear on your Denti-Cal checks/EOBs **are correct**.

If you are incorporated, a valid, legible copy of the Articles of Incorporation showing the name of your corporation must be attached. If your corporation is doing business under a fictitious name, a valid, legible copy of the fictitious name permit issued by the **Dental Board of California** must also be attached.

TAX IDENTIFICATION CHANGE INFORMATION

Provider ID Number _____ Service Office Number _____

Doing Business As Name _____

Tax Identification Number _ _ _ - _ _ - _ _ _ _ ***or*** _ _ - _ _ _ _ _ _ _
(SSN) (EIN)

Billing Provider Name _____
(Please Print)

Billing Provider's Signature _____ Date _____

California Medi-Cal Dental Program

Denti-Cal Bulletin

VOLUME 19, NUMBER 42 P.O. BOX 15609 SACRAMENTO, CALIFORNIA 95852-0609 DECEMBER, 2003

NO CLAIM ACTIVITY FOR 12 MONTHS

The Welfare and Institutions Code states providers who have had no claim activity (submitting no claims or requesting reimbursement) in a twelve month period shall be deactivated. Welfare and Institutions Code Section 14043.62 reads as follows:

> The department shall deactivate, immediately and without prior notice, the provider numbers used by a provider to obtain reimbursement from the Medi-Cal program when warrants or documents mailed to a provider's mailing address or its pay to address, if any, or its service or business address, are returned by the United States Postal Service as not deliverable or when a provider has not submitted a claim for reimbursement from the Medi-Cal program for one year. Prior to taking this action the department shall use due diligence in attempting to contact the provider at its last known telephone number and ascertain if the return by the United States Postal Service is by mistake or shall use due diligence in attempting to contact the provider by telephone or in writing to ascertain whether the provider wishes to continue to participate in the Medi-Cal program. If deactivation pursuant to this section occurs, the provider shall meet the requirements for reapplication as specified in this article or the regulations adopted thereunder.

If you are deactivated and wish to re-enroll, please phone (800) 423-0507 to request an enrollment package. To remain in the Medi-Cal Program, please fill out the form below, stating why you wish to be an active provider. Send the form to: Denti-Cal, California Medi-Cal Dental Program, Post Office Box 15609, Sacramento, CA 95852-0609.

If you have any questions, please call Denti-Cal toll free at (800) 423-0507.

Yes, I wish to remain a provider in the California Medi-Cal Dental Program because _____

_____

Check the boxes that apply to your practice:

- ☐ AAH (Alameda Alliance Health)
- ☐ CCS (California Children's Services)
- ☐ DMC (Dental Managed Care) Plan Name: _____
- ☐ FQHC/RHC (Federally Qualified Health Clinic/Rural Health Clinic)
- ☐ GHPP (Genetically Handicapped Persons Program)
- ☐ GMC (Geographic Managed Care) Plan Name: _____
- ☐ HFP (Healthy Families Program)

_____ Provider Name/Number

_____ Provider Signature